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The Massachusetts Medical Society

PROCEEDINGS OF THE COUNCIL

Stated Meeting, February 3, 1932

A STATED MEETING of the Council was held in John Ware Hall, Boston Medical Library, Wednesday, February 3, 1932, at 12 o'clock, noon. The President, Dr. Halbert G. Stetson, Franklin, was in the chair and the following 127 Councilors present:

BARNSTABLE
W. D. Kinney

BRISTOL NORTH
W. H. Allen
F. A. Hubbard

BRISTOL SOUTH
G. C. King
D. J. Fennelly

ESSEX NORTH
H. H. Nevers
A. P. George
T. R. Healy
J. J. McArdle
F. W. Snow
L. T. Stokes

ESSEX SOUTH
A. E. Parkhurst
F. W. Baldwin
R. E. Foss
E. B. Hallett
W. T. Hopkins
J. F. Jordan
O. S. Pettingill
J. W. Trask

FRANKLIN
R. A. McGillicuddy
H. G. Stetson

HAMPDEN
G. L. Schadt
F. H. Allen
J. M. Birnie
E. A. Knowlton
S. A. Mahoney
M. W. Pearson
A. G. Rice

MIDDLESEX EAST
J. H. Blaisdell
James Blenkhorn
C. E. Montague
F. L. Smalley
F. T. Woodbury

MIDDLESEX NORTH
F. E. Varney
G. A. Leahey
J. A. Mehan
A. G. Scoboria

MIDDLESEX SOUTH
F. W. Gay
C. F. Atwood
C. F. K. Bean
E. H. Bigelow
A. H. Blake
D. F. Cummings
Josephine D. Kable
H. J. Keaney
A. A. Levi
C. E. Mongan
J. P. Nelligan
Dwight O'Hara
J. W. Sever
F. G. Smith
C. H. Staples
E. H. Stevens
H. W. Thayer

NORFOLK
J. W. Ball
F. J. Bailey
F. G. Balch
A. S. Begg
W. L. Burrage
W. S. Burrage
D. G. Eldridge
C. S. Francis
W. A. Griffin
J. B. Hall
W. A. Lane
Olga C. Leary
C. L. MacGray
Charles Malone
S. F. McKeen
T. J. Murphy
W. R. Ohler
Frederick Reis
H. B. C. Riemer
C. A. Rowe
M. V. Safford
H. F. R. Watts
W. A. White
W. H. Young

NORFOLK SOUTH
F. E. Jones
N. R. Pillsbury
C. A. Sullivan

PLYMOUTH
J. J. McNamara
T. H. McCarthy
G. A. Moore
J. P. Shaw

SUFFOLK
A. E. Austin
Horace Binney
Gerald Blake
W. B. Breed
C. S. Butler
David Cheever
R. C. Cochrane
F. H. Colby
F. J. Cotton
A. H. Crosbie
W. P. Cross
Lincoln Davis
G. P. Denny
W. H. Ensworth
John Homans
H. T. Hutchins
E. P. Joslin
T. H. Lanman
R. I. Lee
G. A. Leland
L. S. McKittrick
T. J. O'Brien
A. K. Paine
Louisa Paine Tingley
J. R. Torbert
Conrad Wesselhoeft

WORCESTER
E. L. Hunt
W. P. Bowers
L. R. Bragg
G. A. Dix
G. E. Emery
M. F. Fallon
J. J. Goodwin
E. C. Miller
W. C. Seelye
R. P. Watkins
F. H. Washburn
S. B. Woodward

WORCESTER NORTH
H. R. Nye
F. R. Dame
J. H. Kearney
W. F. Sawyer

Upon motion duly made and seconded it was voted to dispense with the reading of the minutes of the last meeting. The Chair read obituaries of five Councilors who had died in office since the last meeting. He said:

Since the last meeting of the Council we have suffered the loss of five of our members.

Dr. Edmund Farnham Curry was born in Winchester; was graduated from the Harvard Medical School in 1896 and joined our Society in 1898. He settled in Fall River, was on the surgical staff of the Union Hospital and the Fall River General Hospital at the time of his death. He was particularly interested in pediatrics and at one time served as vice president of the New England Pediatric Society. Dr. Curry represented the Bristol South District Medical Society as a councilor from 1916. In 1925 he served as president of his District Medical Society.

He died of heart disease on October 29, 1931 and is survived by a widow and two children.

Dr. Henry Colt was a native of Pittsfield. He was graduated from the Harvard Medical School in 1881 and soon joined the Massachusetts Medical Society. He died suddenly, while asleep, on December 8, 1931. Dr. Colt never married and gave much of his time to hospital and civic activities. He was medical examiner for over thirty years. He was medical director of the Berkshire Life Insurance Company, chairman of the medical board of the House of Mercy Hospital and president of the Pittsfield Anti-Tuberculosis Association. Other positions held by him were president of the Berkshire Athenaeum, the

Berkshire County Red Cross and president of the Massachusetts Medico-Legal Society as well as of the Berkshire District Medical Society. Dr. Colt served his district as a censor and was a councilor from 1906 until his death. He was also a member of the Committee on Permanent Home. He led a very active and useful life.

Dr. George Strong Derby was graduated from the Harvard Medical School in 1900 and joined the Massachusetts Medical Society in 1903. His obituary, which appeared in a recent issue of the *New England Journal of Medicine** was very complete.

Dr. Derby was one of the foremost ophthalmologists in this country and since 1923 occupied the chair of Williams Professor of Ophthalmology in the Harvard Medical School.

He served as councilor for many years and was president of the Suffolk District Medical Society at the time of his death, which occurred suddenly on December 12, 1931 at the age of fifty-six. He is survived by a widow and two children.

As an educator, executive and skilled physician, Dr. Derby will be missed by all.

Dr. Joseph Armand Bedard, 64, of Lynn, a member of the Massachusetts Medical Society since 1890 and a member of the Council, a past president of the Essex South District Medical Society and the Medical Examiner for the Lynn District, died of heart disease at his home on January 26, 1932. Dr. Bedard was a graduate of Laval University in 1890 and began the practice of medicine in Lynn in the same year and always remained there. He was much interested in tuberculosis and was an attending physician of the Lynn Tuberculosis Sanitarium. He is survived by his widow, a son and two daughters.

Dr. Wilfred Gardner Brown, 74, a member of the Massachusetts Medical Society since 1888 and a member of this Council, died at his home in Plymouth on December 12, 1931. Graduating from the Harvard Medical School in 1884 he at once began the practice of his profession at Plymouth, had always remained there and had become most highly honored and esteemed. He was for many years one of the visiting staff of the Jordan Hospital. He had always been much interested in matters relating to public health and was a member of the Massachusetts Association of Boards of Health and of the National Association for the Prevention and Treatment of Tuberculosis.

Dr. T. H. Lanman, Chairman of the Committee of Arrangements, sketched the arrangements his committee had made for the Annual Meeting. It will take place on Wednesday, June 8, Thursday, June 9 and Friday, June 10 at the Hotel Statler, Boston. On Wednesday morning there will be clinics at the Boston City Hospital, the committee having the feeling that good clinics at one hospital would serve the Society better than several scattered in hospitals throughout the city. On Wednesday at 11:30 A. M. will be the meeting of the Supervising Censors, at noon the Council meeting, followed by the Cotting Luncheon, all in the hotel. The afternoon of that day will be devoted to entertainment; the evening, to the Shattuck Lecture by Dr. F. B. Mallory, either at the hotel or at the Boston Medical Library. On Thursday morning there will be meetings of the sections of medicine, and radiology and physiotherapy and the Annual Meeting of the Society at noon. In the afternoon the meetings of the sections of obstetrics, gynecology and tuberculosis will be held in the hotel. The Annual Dinner will be served on that evening in the Ballroom of the Statler. Friday morning sessions of the sections of surgery and of pediatrics will be followed by the Annual Discourse by Dr. S. B. Woodward at noon and a luncheon will close the meeting.

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The report of the Committee of Arrangements was accepted by vote as was the following report of the Committee on Membership and Finance, on membership, presented by Dr. D. N. Blakely, Chairman:

REPORT OF THE COMMITTEE ON MEMBERSHIP AND FINANCE ON MEMBERSHIP

Your Committee makes the following recommendations as to membership:

1. That the following named twelve Fellows be allowed to retire as of December 31, 1931, under the provisions of Chapter I, Section 5, of the By-Laws:

1. Coolidge, John Nelson, Ottawa, Canada, with remission of dues, 1929-1930-1931.
2. Fessenden, Charles Hill, Newton Center.
3. Flagg, Elisha, Boston.
4. Hopkins, Frederick Eugene, Springfield.
5. Johnson, Francis Emerson, Erving.
6. Knowles, William Fletcher, Lenox.
7. Paine, Nathaniel Emmons, West Newton.
8. Stone, Arthur Kingsbury, Framingham Center.
9. Thorndike, Paul, Boston.
10. Treanor, John Peter, Dorchester.
11. Twombly, Edward Lambert, Boston.
12. Vickery, Herman Frank, Brookline.

2. That Edward L. Twombly of Boston be and hereby is nominated by the Massachusetts Medical Society for affiliate Fellowship in the American Medical Association.

3. That dues for 1932 of the following named five Fellows be remitted under the provisions of Chapter I, Section 6, of the By-Laws:

1. Batchelder, William Burdett, Dorchester (Boston).
2. Bush, Arthur Dermont, Decatur, Ga.
3. Donahue, William Francis, Watertown.
4. Hubbard, Joshua Clapp, Wayland.
5. Wilder, Edward Wheeler, Madura, South India.

4. That the following named fifteen Fellows be allowed to resign, as of December 31, 1931, under the provisions of Chapter I, Section 7, of the By-Laws:

1. Attridge, Arthur James, San Bernardino, Calif.
2. Buckman, Thomas Ellwood, Jacksonville, Fla.
3. Camp, John Dexter, Rochester, Minn.
4. Carlisle, Paul Edward, New York City.
5. Dunham, Henry Bristol, Grenlock, N. J.
6. Friedman, Leo Victor, Newton Center.
7. Heath, Elmer Hinckley, Jr., Buffalo, N. Y.
8. Kagan, Solomon Robert, Roxbury (Boston).
9. Metcalf, Julia Tracy, Los Angeles, Calif.
10. Myers, Samuel William, Roxbury (Boston).
11. Neptune, Edgar McClain, Syracuse, N. Y., with remission of dues, 1930 and 1931.
12. Paglia, Jeremiah James, Jr., Worcester.
13. Patten, Stephen Kerr, Watertown.
14. Sawyer, Edward Keyes, Boston.
15. Warren, Hobart Endicott, Palm Beach, Fla.

5. That the following named twenty Fellows be allowed to change their membership from one District Society to another without change of legal residence, under the provisions of Chapter III, Section 3, of the By-Laws:

One from Hampshire to Hampden

1. Petit, Alphonse Herbert, Ware.

One from Norfolk to Plymouth

1. Jones, Edward Earl, Jamaica Plain.

Eleven from Norfolk to Suffolk

1. Butler, David Matthew, Roxbury.
2. Correa, John Francis, Jr., Jamaica Plain.
3. Devine, Bernard Francis, Milton.
4. Dunphy, Herbert George, Roxbury.
5. Everett, Eugene Ellsworth, Westwood.
6. Harding, Edward, Brookline.
7. Heath, Clark Wright, East Milton.
8. Minot, George Richards, Brookline.
9. Morrison, Lawrence Raymond, Jamaica Plain.
10. Sisson, Mitchell, Brookline.
11. Swartz, Jacob Hyams, Brookline.

Six from Middlesex South to Suffolk

1. Daffinee, Ralph Weir, Brighton.
2. DeNormandie, Robert Laurent, Lincoln.
3. Morgan, Charles Russell, Medford.
4. Pittman, Helen Sinclair, Cambridge.
5. Speare, George Spyrounes, Newton Center.
6. Wiggin, Sidney Cushing, Waban.

One from Suffolk to Middlesex South

1. Wilcox, DeWitt Gilbert, Newton Center.

DAVID N. BLAKELY, *Chairman.*

The committee appointed at the June meeting to consider the petition of William James Brown of Boston to be restored to fellowship reported that they did not favor his restoration at this time and their recommendation was accepted by vote; the similar committee on a petition of C. F. Worthen of Boston reported that he be restored under the usual conditions and the Council so voted. A committee of three to consider a petition of C. L. Furcolo of Springfield for restoration was appointed as follows: J. M. Birnie, M. J. Dillon, Jr., J. M. Tracy, and this committee to consider a similar petition of F. P. Lowenstein of Springfield: J. B. Comins, R. B. Ober, Samuel Segal, Jr.

The Chair nominated and the Council appointed the following delegates to the annual meetings of five New England State medical societies:

Maine—J. H. Pratt, Boston; S. W. Allen, Boston and York Harbor, Maine.

New Hampshire—C. C. MacCorison, North Wilmington; T. R. Healy, Newburyport.

Vermont—J. A. Mather, Greenfield; J. J. McNamara, Brockton.

Rhode Island—G. C. King, Fall River; Charles Shanks, New Bedford.

Connecticut—F. B. Sweet, Springfield; E. W. Brown, Northampton.

To attend the Annual Congress on Medical Education, Medical Licensure and Hospitals of the American Medical Association at Chicago, February 15 and 16, 1932: T. J. O'Brien, Boston; H. P. Stevens, Cambridge. Delegates to the House of Delegates, American Medical Association for the term of two years beginning, June 1, 1932:

J. M. Birnie, Springfield; *alternate*, W. C. Leary, Springfield.

C. E. Mongan, Somerville; *alternate*, L. S. McKittrick, Boston.

J. F. Burnham, Lawrence; *alternate*, E. L. Hunt, Worcester.

Dr. C. S. Butler, Treasurer read the following statement and also the report of the Auditing Committee and they were accepted: (For the latter and for the Treasurer's full Report and the Reconciliation of Profit and Loss see Appendix No. 1.)

Mr. President, and the Council:

The 1931 *revenues* from annual dues of Fellows received, first, from District Treasurers of $39,954, secondly, from non-resident dues of $971, and thirdly, additional dues direct to the Treasurer, of $2,003.60, amount to $42,928.60, a large sum, really the largest amount of such dues in our history.

The income, from securities, from savings, and bank interest, in 1931, amounts, in addition, to $4,106.08; the combined total, then, of $47,034.68, also the largest in our history.

Regarding the Society's *cash*, of which there is a large amount from February to October, the Treasurer, because bank interest during the year was very low, has tried to keep this employed with some income and good security, having consideration of the amount required for monthly outgo. He has also taken advantage of the recent low prices for double A and triple A bonds to add to the securities of our "*General Fund*." During the past year all of our investments have promptly paid their interest. On January 1, 1932, several bonds came due and were paid, three with a profit over cost and one at an additional premium. These latter two results speak well for his predecessor in office, Dr. Arthur K. Stone.

The Treasurer is convinced that our Society's funds should be conservatively invested, being guided, in great measure, by the laws which are in force for Massachusetts savings banks, with consideration of *diversification*, so as not to have too large a proportion of our whole in one security. It is good practice, the Treasurer believes, to have some securities mature, and be paid, from year to year. During the past two years, yes during the past three years, we have learned many things about *security* and about "securities". In brief, then, the Treasurer's policy should be: the security of principal is of primary importance; income, is secondary.

Among our other assets, the Society still owns several hundred copies of Dr. Viets' "Brief History of Medicine in Massachusetts," now in the care of the Treasurer. These should be more widely distributed, both among our 4700 Fellows and to libraries of this State and elsewhere. If therefore we can sell them, our Society will benefit, because copies unsold tie up our funds, whereas those sold, add to our treasury. You can help in this distribution, by suggestions to the Treasurer.

Regarding *expenses*, the Treasurer hopes, with your coöperation, to reduce considerably the 1932 expense. There have been in 1931 several non-recurring items, amounting to hundreds of dollars, such as new furniture for the present offices, special contribution to Boston Better Business Bureau, expense of moving from former offices, and Complete Catalog, now published. Your Secretary has kept well within his budget; the Treasurer has gone somewhat over. But, regarding the "expense" of *District Treasurers* and of *Censors*, the Treasurer is glad to have these increase, because that means our Society is growing, the number of our Fellows is increasing. The legal expenses of our Society, year by year, seem large; the Treasurer wishes they might be reduced. The "*dividend*" to District Societies could reasonably be

increased; and the expense for maintenance of Committee rooms should, in 1932, be reduced from that of 1931. Among all expenses, the Treasurer estimates that in 1931 there were items of outgo with a total of about $4,000 which will be eliminated in 1932.

Regarding the *"General Fund,"* the total par value of securities as of December 31, 1931, is $63,274.48. These are diversified; there are a few bonds, however, which give the Treasurer some cause for thought, but all have paid their interest during the year. The details of the General Fund are to be found in the complete report of the Treasurer in these Council Proceedings. The total *assets* of our Society are *$136,291.91*.

The *"Building Fund"* of our Society, to which are added the income from securities in that Fund, the interest from savings bank deposits of the Fund, and interest on the note of $24,703.29 of the Boston Medical Library, has increased, during 1931, to an inclusive total of *$46,507.43*. This "Fund" is increasing yearly from income by about $2,200.

All in all, the Massachusetts Medical Society, in 1931, with a surplus of $3,376.29 to offset previous deficits of 1929 and 1930 of $2,131.90, has had a very successful financial year.

CHARLES S. BUTLER, *Treasurer.*

Dr. Blakely presented the report of the Committee on Membership and Finance, the Budget. (See Appendix No. 2.)

Dr. Blakely continued as follows: You will notice that there are some increases and some items that have been lessened. Beginning with the last one, the increase in dividends to district societies from $4,000 to $5,000. When the dues were increased to $10 per year, the hope was expressed that we should be able to make a larger return to the district societies. This year, fortunately, we are able to recommend an increase of 25 per cent.

The Committee of Arrangements for the Annual Meeting have asked for less than last year. They did not expend all that was appropriated, and we are recommending even less than they expended, because they are confident they will not need so much. Last year, you remember, was the sesquicentennial of the Society. The House of Delegates, American Medical Association, meets this year in New Orleans instead of Philadelphia; hence the increase. The treasurer has already mentioned the fact that if we increase the appropriations for censors and district treasurers, it means greater income for the Society and a larger membership.

The other item of increase is in the so-called salary of the secretary. If we stop to think of it, I presume we all realize something of the high quality of service which has been rendered by our secretary during these 22 years, and yet when we think of the quantity, I am confident not half a dozen Fellows of the Society have any conception of the volume of work nor of its great increase in recent years. The increase is not expected to compensate the secretary for the work done, but it is an expression of appreciation of the high quality and the great quantity of work which he is doing. [Applause.]

The only other item is the total of our appropriations, $45,250, which is less than our total of last year. The income estimated by our treasurer is the same, $45,250. We could not get him to estimate any more because he is conservative.

A MEMBER: May I ask a question. Last year there was a question of bonding the treasurers of district societies at the expense, I believe, of the whole Society. I would like to inquire if that was done and an allowance made for that in the budget.

DR. BLAKELY: The vote which was passed by the Council was that on recommendation of our committee each district society be asked to consider the matter at its annual meeting and take such action as it deemed best. So far as I know, not a single one of the eighteen districts took any action.

DR. W. H. ENSWORTH, Suffolk: Is it necessary to have the annual directory every year? Wouldn't every other year do?

PRESIDENT STETSON: I would like to ask the secretary his feeling about that.

SECRETARY BURRAGE: I do not think the secretary is competent to express an opinion on it. He works very hard on the directory and it takes about three months of pretty intensive work, besides the day to day tabulating of the members as they move about, 4,700 of them. Some of them move every six months [laughter], and it is very difficult to keep track of them. But I try to do that, and try to keep the list in order so far as I can. We started the annual directory in 1911 and it has been going ever since. Previously there was a triennial catalogue without street addresses, but it seemed as if it was a good plan to take account of stock once a year and find out where the men were and try to keep track of them. I think the Annual Directory has raised the morale of the Society. It is to be noted that the Massachusetts Medical Society is unique in several respects. Besides being the oldest State medical society with a continuous existence in the United States it has a weekly medical journal, it has a truly representative body, the Council which meets three times a year to transact the business of the society, it has an Annual Directory and it contains a larger percentage of all the physicians of the State, as listed in the last Directory of the American Medical Association, in societies having more than a thousand members, than any other State in the Union,—something over seventy per cent. The Annual Directory costs $1,650, according to the entry in the Budget.

The Chair suggested that the changes in membership that had occurred during the year could be made up, printed and forwarded to the Fellows early in the year, to be added to the present list as made up by the secretary and that once in two years a new directory issued.

It was moved and seconded that the directory be published biennially and corrections be made on the off years.

Dr. S. B. Woodward said that in his opinion one of the most valuable things the society does is to publish a directory annually; it not only raised the morale but was valuable from every point of view. He thought that the 35 cents apiece it costs is very well spent and hoped it would be continued as an annual. Dr. W. H. Young, Norfolk, thought it would be worth while to save $1,600 and have a biennial directory. Dr. A. H. Crosbie, Suffolk, having been a secretary of a local society, said he appreciated the value of a new directory every year. Dr. Woodward said he kept a directory constantly in both of his two offices and referred to them constantly. Dr. J. A. Mehan, Middlesex North, said that he too had been a District Secretary and kept not only the current copy on his desk but had at hand all the directories issued since he had entered the society and that there was scarcely a day that someone did not come in and want some information from the directory. He hoped the motion would not pass. There being no further discussion the motion was put and lost.

The report of the Committee on Membership and Finance, the Budget, was accepted and its recommendations adopted. (See Appendix No. 2.)

Dr. Shields Warren read the report of the Committee on State and National Legislation and it was accepted. (See Appendix No. 3.) The Chair remarked that House Bill 226 can be opposed for one reason, namely that the chiropractors themselves have the feeling that deaths occurring in their practice are deaths by violence; hence they ask and insist in their act that death certificates be written by the Medical Examiner, lest there be any doubt about it. (Laughter.)

The Chair said: With reference to one matter, I would like to ask Dr. Woodward to speak. He has the feeling in reference to his particular bill, requiring the vaccinating of the pupils of the private schools and I am sure he is right, that a much more active campaign should be carried on in the State Senate than has been done in the past, and particularly I think as he uses the expression bombarding the senators with letters and requests. I would like to hear from Dr. Woodward.

Dr. Woodward: *Mr. Chairman*, I am afraid that if I say everything I want to I shall leave this room without a friend in it. Bombarding! Let me tell you, gentlemen, that three years ago in endeavoring to stir up more support than I had succeeded in obtaining from the Fellows of the Massachusetts Medical Society—and I am very grateful for the hearty support that I have had from a few of them—the Massachusetts Medical Society sent a circular letter at considerable expense to every Fellow of this Society, requesting each Fellow to interview in some form or other their legislators in the House of Representatives and the Senate and report back to the Committee on State and National Legislation the attitude of those individuals, in order that the legislative committee could proceed to take what action they chose. I have forgotten the exact number of Fellows, but it is over 4,500. We received fourteen answers, and fourteen only.

I think the Committee on Public Health will probably report my bill. I think the lower house will pass it. Two years ago over a thousand letters and telegrams went to the Committee on Public Health in opposition, and about five in favor. If in each district you men get busy and not only write to your senator, but get other people to write to him, so that he will receive more letters in favor than against, I have some hope that it will pass. If you don't it won't.

Dr. M. V. Safford, Norfolk: *Mr. President*, It may be of interest to say that as a result of action taken by the Executive Committee of the Massachusetts Association of Boards of Health, the secretary of that association has sent out an appeal to every local board of health in the State— and that means in some instances to the selectmen—asking them to get in touch with their senator in regard to this bill on which Dr. Woodward has just spoken, supplying them with some argument in its favor and asking them to report back to the secretary the result of their interview or personal communication in the matter.

President Stetson: Another suggestion that has been made is that members of this Society endeavor also to get their school superintendents and the proprietors of private schools in their districts to write senators regarding this bill.

[Upon motion duly made and seconded, the report of the Committee on State and National Legislation was accepted.]

Dr. T. J. O'Brien, Suffolk, Chairman of the Committee on Permanent Home, read a report. (See Appendix No. 4.)

President Stetson: You have heard the report of this Committee on Permanent Home. The recommendation is made that this be made a standing committee. Is that right, Dr. O'Brien?

Dr. O'Brien. Yes.

Dr. W. P. Bowers, Worcester: *Mr. Chairman*, I would like to second the motion which is incorporated in the report of this committee. That report carries with it the recommendation for the adoption of a committee to be made a standing committee and, therefore, it carries

with it the implication that the present committee in charge of the permanent home shall be made a permanent committee, and also that there shall be incorporated in the by-laws a copy of the recommendation of this committee. In order to have it adopted, it is necessary that it have the approval of the Council and then come before the annual meeting of the State Society. In other words, the motion of the committee, if passed, will carry approval of the recommendation for incorporating into the by-laws the specific language which has been suggested and making the committee a standing committee of the Society.

PRESIDENT STETSON: I would like to ask, Dr. Bowers, if this committee were made a permanent committee instead of a standing committee, would that require any change in the by-laws?

DR. BOWERS: If you simply specify it or name it as a permanent committee that does not give it the standing which it would have if it is provided in the by-laws that it so rank with the other standing committees.

PRESIDENT STETSON: In other words, it would be necessary to change the by-laws, in any event.

DR. BOWERS: I think that you should incorporate this amendment to the by-laws as suggested by Dr. O'Brien.

PRESIDENT STETSON: I think first the question should be on the acceptance of this report.

[Upon motion duly made and seconded, the report of the Committee on Permanent Home was accepted.]

PRESIDENT STETSON: Now comes up the question proposed by Dr. O'Brien, and I will ask Dr. O'Brien to read that motion again so that it may be entirely plain to all of you.

DR. O'BRIEN: [Re-reading motion contained in above report.] In introducing this motion, gentlemen, it is for the purpose of simplifying the handling of our headquarters. We feel that if the committee is retired and this is accepted as a final report, the fund remains inactive. There are possibilities of bequests and contributions to this fund which should grow and should be in the hands of some committee. The motion that was made and passed at the last Council meeting gives the treasurer authority to add the interest on this building fund to the principal. We thought this was the simplest way of disposing of a rather troublesome feature.

PRESIDENT STETSON: The secretary has a question which he wishes to ask?

SECRETARY BURRAGE: All the eight standing committees at present have five members each. That was arranged when the By-Laws were last revised in 1928. The question of the number of standing committees has been considered many times at the revisions of the By-Laws. It was thought best to make them uniform and to have not too many, only those which manage the affairs of the society directly. I should like to ask why this proposed standing committee should have seven members when all the others have five?

DR. O'BRIEN: May I answer that?

PRESIDENT STETSON: Yes.

DR. O'BRIEN: The committee was organized to cover the State. The membership comprised T. J. O'Brien, S. B. Woodward, Henry Colt, C. G. Mixter, J. M. Birnie, R. B. Greenough, W. G. Phippen. That gives three members from Boston and four members from other parts of the State, which we felt was a well-balanced committee and one which represented all portions of the State. It does not give Boston predominance on the committee, and this committee has worked well together. I think Dr. John M. Birnie might say a word because he appointed this committee of seven in 1929. I dislike to have it cut down.

DR. J. M. BIRNIE, Hampden: *Mr. President* I am very anxious that some standing committee be appointed. I do not think it is essential whether that committee have seven members or five. But this fund, as you see, is nearly $47,000. It is going to grow at the rate of two to three thousand dollars every year, and very shortly we are going to have a considerable sum of money, and, as has been said, someone has to arrange for the permanent home or a temporary home or the hiring of these quarters, and it should be on a suitable basis. It is part of the affairs of the Society. I am very strenuously in favor of seeing this amendment pass. I am willing that it should be five instead of seven, if you think that is enough.

DR. BOWERS: May I have the floor for a moment?

PRESIDENT STETSON: Dr. Bowers.

DR. BOWERS: The conditions as they exist at the present time require some explanation. As you know, we are very pleasantly situated in the Boston Medical Library, but if you listened to this report you will have noted that it is necessary from time to time for this committee to be in conference with the officials of the library in order that the further arrangements shall be completed. That is, this whole thing has to be reconsidered at intervals. The present arrangement extends only to 1936, if I remember correctly, with an adjustment some time within the next two years. That is right, Dr. O'Brien?

DR. O'BRIEN: Correct.

DR. BOWERS: That carries with it the implication that we are to be in conference with the Library from time to time in order to determine the conditions under which the Library provides for the accommodations of the Society. As I said a moment ago, the relations at present are amicable and pleasant in every way,

with the hope that this arrangement will last for a very considerable period of time, but you must bear in mind that the construction of this Library provides for the use of a wing by the Society, and at some time when the Library may be able to make use of it by reason of its growth, the Massachusetts Medical Society has no assurance, however pleasant our relations may be with the Library at the present time, that it will be a permanent arrangement beyond the time when the Library may see fit to use that wing. If the Massachusetts Medical Society has in contemplation a permanent home, we must consider this particular arrangement as possibly only a temporary one and the committee which should have in charge this matter should be a permanent committee, first, because, as I said, it requires continuous adjustment from time to time with the Library and, secondly, because of the possibility that it may be necessary at some time to provide other accommodations and the Society has to adapt itself to the policy of eventually establishing what may be termed a permanent home.

PRESIDENT STETSON: The question is, Do you wish to accept this motion of Dr. O'Brien's to be finally voted upon at the annual meeting in June? Is that right, Doctor?

DR. O'BRIEN: No, sir. I think we must pass it now and then it is referred to the annual meeting of the Society for action. We cannot appoint a standing committee at one meeting of the Council, if I understand the By-Laws.

PRESIDENT STETSON: You hear the correction of Dr. O'Brien.

[The motion, being duly seconded, was carried.]

Dr. W. G. Curtis, Norfolk-South, read the report of the Committee on Public Relations and the report of the sub-committee. (See Appendix No. 5.)

[Moved and seconded that the foregoing reports be accepted.]

DR. F. J. COTTON, Suffolk: *Mr. President and Fellow Members.* It seems to me that we are in danger of damaging ourselves if we accept this kind of a report. Of course, a great deal of what has been said is true. There has been a certain amount of encroachment. We all feel that what we call state medicine is very undesirable. We feel that in one form or another we should do all we can to limit the extent to which so-called state medicine is going to take over our work. But I think we have to remember that the standing of the medical profession, and particularly of this Society and its influence in the Commonwealth, is not what we would like to see it. We are in some measure discredited because, perhaps not through our fault, we have not done very much constructive work from the point of view of public health.

The danger, I think, is that if we accept this kind of a report and go ahead on this basis—and of course our action is going to become public, as all such things do—we are going to find things happen as they happened recently in the cancer clinic, where the legislators—not the Commissioner of Public Health, but the legislators—are going to get up and say that clinics are going to be established. We shall have no influence in the matter, and we are simply going to discredit ourselves by trying to sweep back the tide with a broom. It seems to me if we can work with the Commissioner of Public Health, who is, as we all know, a man of ability who is not trying to encroach at all, if we could try to coöperate through him instead of declaring ourselves in opposition, we can finally get things in better shape. I have that feeling very strongly. I think many others have. It is not a matter of opposing any encroachment, but it is a question of recognizing the fact that of necessity, as the years go by, there will be things that come up that will be handled by the State that you and I cannot handle, that private interests won't handle and they have got to become State activities. For instance, many of you know what has been done in poliomyelitis work this last season, magnificent work that could not be handled by private agencies. I happen to have bumped into that constantly, and I know of case after case that could not be handled by private agencies or private practitioners that was handled by the State Department of Health. That is one of the things.

There are certain things such as the cancer clinics that have been criticized somewhat; how justly I don't know. They were an activity of the State, but not of the Commissioner of Public Health. Pondville seems to be run very well. Lakeville I am not so sure about. The other clinics that the Commissioner has been more or less mixed up with are not run by him so much, but by women in agencies who want to carry on social activities.

Now I wonder if we want to put ourselves in apparent opposition with a power over which we have no control and with whom we have no influence. It is not a question of what we want to see happen, but it is a question of whether we want to put ourselves in the hole or not.

I don't know whether Dr. Bigelow is here or not, he happens to be chairman of that Public Health Council. He knows the situation. Dr. Bowers knows it well. Dr. Goodall knows it. I think we ought to hear what the situation is and what men think of it who watch it without any partisan interest and watch it from the outside. I think we ought to be very careful in considering this report.

DR. C. E. MONGAN, Middlesex-South: *Mr. President.* I do not think we are in any danger of anything. I think the time has come

for the Society to assert itself. This report distinctly says—and it was moved and seconded and passed—that a sub-committee of this committee be appointed to confer with the Public Health Council with regard to questions raised in the committee, and to assist the Department of Public Health that greater coöperation may be achieved with that Council and general practitioners. What is the harm in that?

I think the committee has been very conservative in its report, considering the number of complaints to which the Commissioner of Public Health listens. This committee asks for coöperation. It is not necessarily going to be antagonistic to the Health Council or to the Commissioner of Public Health. Who owns the public health, anyway? To whom does the Commissioner belong? To the citizens of Massachusetts. And is it wrong—do we overstep—when we, as citizens, ask that we have a conference with any public board or any public official? I think not.

It was moved and seconded that it is the sense of this committee that the State Department of Public Health is encroaching, wittingly or unwittingly, upon the general practice of medicine. That is true. Is there any harm in calling the attention of a public board to the criticism of a difference of opinion that any citizen of the Commonwealth may have of that board? I do not see that it is. Neither do I see that we are letting ourselves in for anything. We have asked for a conference. We do not say that the activities of the Department of Public Health are right or wrong.

Necessarily, it is incumbent upon the Department of Public Health and its Council to do certain things in the interests of the public, not certain private things that make it a competitor in practice with the ordinary physician. We ask for a conference. I think that is the only way to go about it. We can compromise and we can direct and assist the Department of Public Health, very well. And that is all this report asks. We are perfectly willing that every citizen of the Commonwealth should read it, should criticise it, and give his opinion. This is a report of compromise, of conference, of coöperation. The English is plain. You cannot adduce any other opinion from it but that of compromise and coöperation, and also with the fact in view that we are trying, so far as we can, to preserve the rights of the profession and the rights and privileges of the community. That is all it is about. [Applause.]

Dr. W. A. Lane, Norfolk: *Mr. President, and Members of the Council.* I happen to be a member of the committee on public relations and I am speaking entirely without any personal feeling, so far as private practice is concerned, but we have heard in the committee of a great many instances in which there seemed to be grounds for the feeling of the practitioners involved throughout the State, not in any one district, that they have been discredited, and possibly some of them have felt from the attitude of the State Department of Health in its activities that they have been humiliated in their private practice of medicine.

We do not believe that the doctors in general, the practitioners in general, are always right. Neither do we believe that the State Department of Public Health is always right. We believe that the field is very broad, that the question is large, and cannot be settled in a few meetings, nor possibly in a few months, but that there are certain general principles of ethics, of right dealing, of right practice, that can be and should be ironed out. Our attitude is one, as Dr. Mongan has said, that the report we hoped had stated, one in which we are willing and eager to coöperate. Our understanding is from the Commissioner of Public Health, by direct word at our meeting and before one of the district medical societies and to the president of this Society, that he is very eager to coöperate. That being the case, it certainly seems as though our path is smoother and is likely to be smoother than it might be when any spirit of antagonism exists on the one side or the other. I hope you will accept this report in the spirit that it is offered and realize that your committee as a whole is extremely diffident in its relation to giving any opinion, or expressing any idea that we are not humble in our attitude, and also that we wish to preserve the spirit of self-sacrifice and the spirit of well-being of the indigent individual whom we feel that we of the profession are taking care of and are able to take care of better through individuals than through State medicine. The question is broad, and I believe that, given time to work on it and with the attitude of the committee and the attitude of the Commissioner of Public Health, we will get together for the common good. [Applause.]

Dr. S. A. Mahoney, Hampden: *Mr. Chairman.* At the last meeting of the Council I believe I had something to do relative to starting the wheels of this committee going. I know that up in our part of the State there is no doubt at all that the conclusions arrived at by this committee that have talked over this thing from all parts of the State are sound, and I never saw a committee yet appointed that agreed so thoroughly in regard to the questions under discussion. From what the members from the various parts of the State said at those meetings I thought that the report would be much more drastic than it has been presented to the Council. There is no member of that committee that did not agree on the first thing that was voted on, and that was: It was moved, seconded and passed that it was the sense of this com-

mittee that the State Department of Public Health is encroaching, wittingly or unwittingly, upon the general practice of medicine. And I do not think there is any one of you that is out in private practice, not connected with the large institutions in the metropolitan centers, but will agree to that section. Then it was moved and seconded and passed that a subcommittee of this committee be appointed to confer with the Public Health Council to see if we cannot correct in a slight degree what is going to be done relative to medicine in the State of Massachusetts. Then, fourthly, it was moved and seconded and passed that it is the opinion of this committee that the State Department of Public Health should not establish further hospitals, as for the care and treatment or research of chronic diseases, such as diabetes, heart disease, arthritis, nephritis or any chronic disease.

Now, members of the Council, we know well that we get very little from the scientific research that is done in public hospitals under political control. In my mind, if there is anything of that sort to be established, it should be established under the care and control of already established, well-known hospitals such as the Massachusetts General, the Peter Bent Brigham or the Boston City, where the conclusions can be relied upon. As I say, gentlemen, I never saw a committee so unanimous in their conclusions as this committee, and there were members from every part of the State at the meetings. [Applause.]

Dr. George H. Bigelow, Suffolk: I am sorry that Dr. R. I. Lee, a member of the Public Health Council, has left the meeting. As chairman of the Public Health Council, and I am sure I speak for the other members of that council as well, I say that we welcome the appointment of this committee with which we may discuss these problems. It may appear from the discussion here that Massachusetts is cursed with a fungous growth in its State Department as another part of the country is, but I can assure you that every health officer, State or local, the country over, is acutely conscious, night and day and at twilight, of the problem of the relationship between him, an official of the Public Health Department, and the private practice of medicine. I do not suppose in the sum total of hours of thought that health officers give more thought to anything than to that one thing.

There is, I think, likelihood of there being some confusion in blaming on the State Department of Public Health any activity that anyone seems to run into, official or voluntary, in the line of health welfare. This is going on all over the country, whether we like it or not, and nobody can stop it, so far as I can see. In the discussion which I was privileged to have with this committee there were a number of activities cited as encroachments, that were under the jurisdiction of local boards of health, of local private agencies, of the Department of Mental Diseases, and so on. I think it is not a development, but a movement, a social movement, if you will, that the committee is viewing with apprehension. I think the important thing to keep in mind is that the movement will continue. I mean what I do, what happens at the moment, has nothing to do with it. It is the long term view of this movement which cannot be stopped.

If this committee is to meet with the Public Health Council in order to guide it in the solution of some of these problems which must be solved, it will be extremely profitable for us. If the committee meets with us to obstruct anything being done in these fields, it will be a waste of everybody's time. [Applause.]

Dr. J. H. Lambert, Middlesex North: It seems to me there is one point in these resolutions which might possibly be, in the words of Dr. Bigelow, an obstruction or in conflict. At the present time I don't know whether anybody has any particular feelings about the establishment of further hospitals in this Commonwealth or not. I think Dr. Cotton's words were very much to the point in regard to what might happen if obstruction were put forth by the medical profession; that the Legislature might do exactly the same thing they did in the establishment of the cancer clinic, in which the Department of Public Health was not responsible. The movement came from a layman. It seems to me that part of these resolutions which state the opinion of the committee that they are opposed to the further establishment of hospitals ought not to be accepted by this Council. The other part of it I think perhaps is all right. I have no desire to see them established. I do not know even that it is intended to establish such hospitals, but I think it would be a very foolish thing for this Council to accept that portion of the report which distinctly states that as a thing which is evidently only an apprehension in the minds of the committee. I believe that that part of it should not pass, and I should be very much opposed to it in its present form. If necessary, if it were to be passed in this form, I should offer a motion to lay the whole thing on the table at the present time for further consideration.

Dr. Mongan: May I read again for the benefit of Dr. Lambert:

> "It was moved, seconded and passed that it is the opinion of this committee that the State Department of Public Health should not establish further hospitals as for the care, treatment or research of chronic diseases such as diabetes, heart disease, arthritis, nephritis or any other chronic diseases."

That is our opinion. That opinion in the minds of the sub-committee will be discussed with the Public Health Council. We may change our opinion. It does not commit the Council to any State policy. It is the opinion that they should not be established. Now, perhaps, after a conference with the Council of the Department of Public Health we might change our opinion. It does not tie us to any hard and fast opinion. It is subject to discussion between the two large bodies, one representing the medical profession and one representing the Commonwealth. I think that you could trust the committee to sit down with the Public Health Council and discuss these things man to man. That is all it asks for.

DR. M. W. PEARSON, Hampden: As a general practitioner, I want to say that the State Department of Public Health is carrying out work along the lines of medicine that never has been done, and cannot be done without the assistance and guidance of the State Department of Public Health. I hope this Society will not register itself in opposition in any way to the work that the State Department of Public Health is doing. [Applause.]

DR. R. A. MCGILLICUDDY, Franklin: I am glad that I am here to hear Dr. Bigelow, because he speaks of improvement in the outlook. He certainly has shown some today, because when in Greenfield he addressed us physicians in the Franklin District Medical Society as "doctors", and he referred to the doctors throughout the State. Today we are doctors. Another thing I would like to mention here, as long as coöperation has been spoken of. We do want to coöperate. But as a medical society, a district medical society of this Massachusetts Medical Society, we sat and listened to some of his remarks, and one of his remarks was, "If the State Legislature appropriates money for a certain thing and tells us to do it, the State Department of Health is going to do it, regardless of whether you physicians want it or not." Is that the spirit of coöperation? No. I think this committee will be in coöperation. I, as one of the members, will try to be. But I cannot forget that remark.

DR. E. L. HUNT, Worcester: I just feel that the doctor very much misunderstood the purport of Dr. Bigelow when he said that the State Department of Health would do it whether the doctors would like it or not. He meant that the Legislature was the power which started these things and provided the means for carrying them out and, as the Commissioner of the Department of Health, it was up to him to do it. It is merely that the Department of Health is the agent of the State. I do not think we need to get excited over this thing. I think we all know that Dr. Bigelow has preserved and been careful of the influence of the general profession. I think it may be quite proper to pass the resolutions that are before the house. I do not think it is easy to get sore on Dr. Bigelow. I think he has been a mighty good friend of the doctors. I think he takes good care not to encroach knowingly. I think perhaps some of his hirelings do and some of those who have less conception of the importance and the difference between general practice and the public health work. I think possibly they sometimes overstep, but I do not think we have any right to blame Dr. Bigelow or the Department on that account. I am in favor of the passage of these resolutions or, at least, the acceptance of them down to the point where we get to the hospitals.

DR. MONGAN: May I ask the gentleman a question? Dr. Hunt, you didn't, as a member of this committee, make any special protest about that?

DR. HUNT: As a member of the committee, I did not vote for that.

DR. MONGAN: Silence gave consent.

DR. L. S. MCKITTRICK, Suffolk: May I ask this question,—whether or not the acceptance of this report by the Council means the opinion of the committee becomes the opinion of the Council, or whether it means we appreciate the efforts of the committee as made and are in favor of them? I think there is a great deal of difference between the two. I think we here would have to be very careful about accepting and having their opinion made our opinion without knowing more about the motions they went through in forming that opinion.

PRESIDENT STETSON: In regard to Dr. McKittrick's question, I should feel that any action taken by the Council as an action accepting this report would mean that the Council accepted it as their personal feelings also.

DR. MCKITTRICK: May I make then a motion or an amendment?

DR. MONGAN: I don't think you are entitled to. I am enlightening you about the work of that sub-committee. You see we have been very careful about this thing:

"Resolved that it is the opinion of this committee"—this is the committee that has been appointed to meet the Public Health Council, and this is the resolution which guided them—

> "Resolved it is the opinion of this committee that the establishment of hospitals and clinics by the Department of Public Health should not proceed further without consultation and coöperation with representatives of the doctors of medicine licensed to practice in this Commonwealth."

Now, that does not commit the Society to anything. That is a resolution for the guidance of the committee. As I said twice before, this is a committee of progress, and this report that we

are making is a report of progress, because it was said that we should report here at this meeting. Does that answer the question?

DR. HUNT: Where the committee say something about conscious or unconscious encroachment, is that in regard to hospitals?

DR. MONGAN: Wittingly or unwittingly. That is in the main report.

DR. HUNT: That is, if accepted, the belief of this Council.

DR. MONGAN: Yes, sir.

DR. JOHN HOMANS, Suffolk: I think the main difference in this matter is in the wording of the resolutions of the sub-committee. I think a good many of us would feel that the Society was in a position of having a chip on its shoulder, or at least it would appear to have a chip on its shoulder. These resolutions I think might be remade in such a way as to be acceptable. The purpose obviously is quite proper. I myself should vote against them on the ground that the wording has not been carefully enough considered. It puts the Society in a position which, if the report were generally published, would be unfortunate.

DR. LAMBERT: I feel exactly the way the preceding speaker feels, in that it specifies in this report certain things as the opinion of this Society, if it accepts it, that we are against, which I think could be easily eliminated, and we would all be perfectly in agreement. I think we all agree that we ought to have a conference with the State Department of Health, and I know Dr. Bigelow does. I think he has been rather abused today. I move that the question be laid on the table.

[Motion seconded.]

PRESIDENT STETSON: You hear the motion that this be laid on the table. The motion is not debatable.

[The motion was put to a voice vote.]

PRESIDENT STETSON: The Chair is in doubt.

[On a rising vote, Dr. W. G. Curtis and Dr. J. W. Sever acting as tellers, 55 votes were recorded in favor and 49 against, and the motion to lay on the table was declared carried.]

DR. MONGAN: May I rise to express an inquiry as to what becomes of the report of the committee?

PRESIDENT STETSON: The original motion last October was that the committee should be of a continuing character from year to year, and it was so voted.

DR. MONGAN: There isn't any question before the house. It is a question of a ruling from the Chair.

PRESIDENT STETSON: My ruling is that the committee continues.

[Upon motion duly made and seconded that the meeting be now adjourned, the question was put and the motion prevailed without dissent. Thereupon the meeting was dissolved, at 2.12 p. m.]

WALTER L. BURRAGE, *Secretary.*

APPENDIX TO THE PROCEEDINGS OF THE COUNCIL

APPENDIX NO. 1

REPORT OF AUDITING COMMITTEE

January 22, 1932.

As Auditing Committee, we have examined the securities of the Massachusetts Medical Society, including those of the Building Fund, in the care of the Treasurer, as of December 31, 1931. We found them correct, and present, with the exception of $3000.00 (par) Mallory Steamship Co. bonds and $1000.00 (par) American Sugar Refining Co. bond, both of which were due or called for payment on January 1, 1932; and the proceeds of both issues were accounted for on the Treasurer's books.

RANDOLPH C. HURD,
ROBERT H. VOSE.

January 30, 1932.

The Auditing Committee
The Massachusetts Medical Society
Boston, Mass.

Gentlemen:

At the request of your Treasurer, Dr. Charles S. Butler, we have audited the books and accounts of The Massachusetts Medical Society for the twelve months ended December 31, 1931 and submit herewith the following:

Schedule A	Statement showing the Assets and Liabilities of The Massachusetts Medical Society December 31, 1931
Schedule B	Statement showing the Current Account of The Massachusetts Medical Society for the twelve months ended December 31, 1931
Schedule C	Statement showing the Reconciliation between the Profit and Loss and the Budget for the twelve months ended December 31, 1931

The cash on deposit in the banks has been reconciled with the bank statements and found correct. All known cash receipts have been properly accounted for, and vouchers or cancelled checks were found to support all disbursements.

We have made no examination of the securities in the various funds.

The attached statement showing the financial condition of the Society on December 31, 1931 is true, to the best of our knowledge and belief.

Respectfully submitted,
HARTSHORN & WALTER.

TREASURER'S REPORT

SHOWING THE ASSETS AND LIABILITIES OF THE
MASSACHUSETTS MEDICAL SOCIETY
DECEMBER 31, 1931

SCHEDULE A

ASSETS

Cash			
Merchants National Bank		$3,750.00	
New England Trust Co.		2,894.35	
			$6,644.35
Investments			
Endowment Funds:			
Shattuck Fund:			
Annuity Policy Mass. Hospital Life Ins. Co.		$9,166.87	
Phillips Fund:			
$10,000 Comm. of Mass. 3½s 1944		10,000.00	
Cotting Fund:			
Deposit in Institution for Savings in Roxbury and Vicinity	$1,000.00		
Deposit in Provident Institution for Savings in the Town of Boston	1,000.00		
Deposit in the Suffolk Savings Bank for Seamen and others in Boston	1,000.00		
		3,000.00	
			22,166.87
Building Fund:			
Deposit in the Framingham National Bank, Savings Dept.		$2,194.32	
Deposit in the Franklin Savings Bank of the City of Boston		1,038.32	
$5000 Canadian National Ry. 5s 1969		4,950.00	
5000 Conveyancers Title Insurance & Mtge. Co. 5½s Parti-Mortgage Oct. 31, 1934		5,000.00	
5000 Chicago, R. I. & Pacific Ry. 1st 4s Apr. 1, 1934		4,735.00	
2000 Northern Ohio Traction & Light Co. Series A 6s 1947		1,886.50	
2000 N. Y., Chicago & St. Louis Ry. 6s Oct. 1, 1932		2,000.00	
Boston Medical Library Note 4½% due Apr. 1, 1933		24,703.29	
			46,507.43
General Fund:			
Deposit in Franklin Savings Bank of the City of Boston		$1,074.48	
$1000 American Sugar Refg. Co. 6s Jan. 1, 1937		988.25	
1000 American Tel. & Tel. Co. Deb. 5½s Nov. 1943		985.00	
3000 Appalachian Elec. Power Co. 5s May 1956		2,910.00	
Boston and Albany R. R. 4s May 1, 1935		995.00	
3000 Cedar Rapids Mfg. & Power Co. 1st 5s Jan. 1, 1953		2,805.00	
3000 Central Power & Light Co. 1st 5s Aug. 1, 1956		2,730.00	
1000 Commonwealth Edison 3½s July 30, 1932		998.80	
3000 Commonwealth of Australia 5s July 15, 1955		2,985.00	
4000 Commonwealth of Massachusetts 3½s 1935		4,000.00	
1000 Commonwealth of Massachusetts 3½s 1941		1,000.00	
2000 Conveyers Title Ins. & Mtge. Co. Parti Mtge 5½s Dec. 1, 1932		2,000.00	
3000 Dayton Power & Light 5s June 1, 1941		2,797.50	
2000 Great Northern Ry. Co. 5½s Jan. 1, 1952		1,932.50	
3000 Guarantee Title & Trust Corp. 5½s Oct. 1936		3,000.00	
3000 International Paper Co. 6s March 1, 1955		3,076.00	
3000 Mallory S. S. Co. 5s Jan. 1, 1932		2,760.00	
2000 Metropolitan Ice Co. 7s Jan. 1, 1954		2,100.00	
1000 N. Y., Chicago & St. Louis R. R. 6s Oct. 1, 1932		1,000.00	
4000 Public Service Co. of No. Illinois 5s Oct. 1, 1956		3,640.00	
1000 Southern Pacific Ore. 4½s 1977		875.00	
1000 Southern Pacific Ore. 4½s 1977		730.00	
3000 Toledo Edison Co. Gold 5s 1947		2,805.00	
3000 U. S. Cold Storage Co. 6s Jan. 1945		3,000.00	
5200 U. S. Liberty 4¼s 1938		5,043.23	
2000 U. S. Rubber Co. 5s Jan. 1, 1947		1,735.50	
3000 Wilson Co. Inc. 1st 6s Apr. 1, 1941		3,006.00	
			60,972.26
New England Journal of Medicine			1.00
Total			$136,291.91

LIABILITIES

Endowment Funds		
Shattuck Fund:		
G. C. Shattuck 1854, Balance 1866	$9,166.87	

Phillips Fund:		
Jonathan Phillips 1860	10,000.00	
Cotting Fund:		
B. E. Cotting $1000—1876-1881-1887	3,000.00	
		$22,166.87
Building Fund—Principal	$44,915.34	
Income	1,592.09	
Balance		46,507.43
General Fund		
Balance, January 1, 1931	$64,231.32	
Rudnick Charitable Foundation Donation	10.00	
Add,—Increase for the year—*Schedule B*	3,376.29	
Balance, December 31, 1931		67,617.61
Total		$136,291.91

STATEMENT
SHOWING THE CURRENT ACCOUNT OF THE MASSACHUSETTS MEDICAL SOCIETY FOR THE TWELVE MONTHS ENDED DECEMBER 31, 1931

SCHEDULE B

REVENUE

Assessments Received by District Treasurers:			
Barnstable		$340.00	
Berkshire		996.00	
Bristol North		570.00	
Bristol South		1,946.00	
Essex North		1,812.00	
Essex South		2,446.00	
Franklin		350.00	
Hampden		2,770.00	
Hampshire		490.00	
Middlesex North		1,046.00	
Middlesex East		920.00	
Middlesex South		6,682.00	
Norfolk		6,342.00	
Norfolk South		832.00	
Plymouth		1,252.00	
Suffolk		7,078.00	
Worcester		3,354.00	
Worcester North		728.00	
			$39,954.00
Assessments Received by Treasurer			2,003.60
Non-Resident Assessments			971.00
Sale of Directories and Dr. Viets' Short History			311.14
Income from Funds			
Shattuck Fund:			
Annuity Mass. Hospital Life Ins. Co.		$435.43	
Phillips Fund:			
Interest—Massachusetts 3½s 1944		350.00	
Cotting Fund:			
Interest—Institute for Savings in Roxbury and its Vicinity	$45.00		
Interest—Provident Institution for Savings in the Town of Boston	42.50		
Interest—Suffolk Savings Bank for Seamen and others in Boston	42.50		
		130.00	
General Fund:			
Interest—American Sugar Refg. Co. 6s 1937	$60.00		
Interest—American Tel. & Tel. Co. Deb. 5½s 1943	55.00		
Interest—Appalachian Elec. Power Co. 5s 1956	150.00		
Interest—Boston and Albany R. R. 4s 1935	7.23		
Interest—Cedar Rapids Mfg. & Power Co. 1st 5s 1953	150.00		
Interest—Central Power & Light Co. 1st 5s 1956	150.00		
Interest—Commonwealth Edison Co. 3½s 1932	1.26		
Interest—Commonwealth of Australia 5s 1955	150.00		
Interest—Commonwealth of Mass. 3½s 1935	140.00		
Interest—Commonwealth of Mass. 3½s 1941	35.00		
Interest—Conveyers Title Ins. & Mtge. Co. 5½s 1932	110.00		
Interest—Dayton Power & Light Co. 5s 1941	150.00		

Interest—Great Northern Ry. Co. 5½s 1952	110.00		
Interest—Guarantee Title & Trust Corp. 5½s 1936	165.00		
Interest—Great Barrington Note	29.28		
Interest—International Paper Co. 6s 1955	180.00		
Interest—Mallory S. S. Co. 5s 1932	150.00		
Interest—Metropolitan Ice Co. 7s 1954	140.00		
Interest—N. Y., Chicago & St. Louis R. R. 6s 1932	60.00		
Interest—Public Service Co. of No. Ill. 5s 1956	200.00		
Interest—Southern Pacific Ry. Ore. 4½s 1977	6.88		
Interest—Southern Pacific Ry. Ore. 4½s 1977	14.88		
Interest—Toledo Electric Co. Gold 5s 1947	150.00		
Interest—U. S. Cold Storage Co. 6s 1945	180.00		
Interest—U. S. Liberty 4¼s 1938	221.00		
Interest—U. S. Rubber Co. 5s 1947	100.00		
Interest—Wilson Co. 1st 6s 1941	180.00		
		2,999.49	
Income from Deposits in Banks:			
Interest—Franklin Savings Bank	$49.93		
Interest—First National Bank	37.29		
Interest—New England Trust Co.	103.94		
		191.16	
			4,106.08
Total			$47,345.82

EXPENSES

Salaries:			
Secretary	$2,500.00		
Treasurer	500.00		
Assistant to President	3,125.00		
		$6,125.00	
Expenses of Officers and Delegates:			
President	$168.37		
Secretary	666.91		
Treasurer	354.80		
District Treasurers	2,327.78		
Censors	683.70		
Delegates to American Medical Association	427.19		
Delegates to New England Medical Council	70.23		
General Expenses:			
Rent Boston Medical Library	900.00		
Shattuck Lecture	200.00		
Cotting Luncheons	251.00		
Miscellaneous Expenses	35.19		
Section of Obstetrics and Gynecology	193.30		
		7,253.35	
Committee Room Expenses		2,885.11	
Dividends to District Societies		4,000.00	
Standing Committees:			
Committee of Arrangements 150th Anniversary	$3,189.20		
Publications:			
A *New England Journal of Medicine*	$15,000.00		
B Annual Directory	1,329.32		
C Complete Catalogue 1781-1931	1,783.45		
		18,112.77	
Membership and Finance	$14.85		
Ethics and Discipline	611.65		
State and National Legislation	328.88		
Public Health	19.50		
		974.88	
Malpractice Defense	2,154.10		
Special Appropriation Better Boston Business Bureau	250.00		
		23,706.07	
Total Expenses			43,969.53
Surplus			$3,376.29

(Signed) CHARLES S. BUTLER, *Treasurer.*

THE MASSACHUSETTS MEDICAL SOCIETY

RECONCILIATION

BETWEEN THE PROFIT AND LOSS ACCOUNT AND THE BUDGET

FOR THE TWELVE MONTHS ENDED DECEMBER 31, 1931

SCHEDULE C	Profit and Loss Account	Budget Estimate	Difference Under Estimated	Difference Over Estimated
REVENUE				
Assessments	$42,928.60			
Income from Investments	3,914.92			
Interest on Bank Deposits	191.16			
Miscellaneous Revenue	311.14			
Total Revenue	$47,345.82	$46,000.00	$1,345.82	
EXPENSES	43,969.53	46,000.00		$2,030.47
Surplus	$3,376.29		$3,376.29	
SUMMARY OF EXPENSES				
Salaries				
Secretary	$2,500.00	$2,500.00		
Treasurer	500.00	500.00		
Assistant to President	3,125.00	2,500.00	$625.00	
Expenses of Officers and Delegates				
President and Vice-President	168.37	500.00		$331.63
Secretary	666.91	775.00		108.09
Treasurer	354.80	300.00	54.80	
District Treasurers	2,327.78	1,875.00	452.78	
Censors	683.70	600.00	83.70	
Delegates to House of Delegates, American Medical Association	427.19	600.00		172.81
Delegates to New England Medical Council	70.23	150.00		79.77
General Expenses				
Rent—Boston Medical Library—9 Mos.	900.00	900.00		
Maintenance of Society Headquarters	2,885.11	2,400.00	485.11	
Shattuck Lecture	200.00	200.00		
Cotting Luncheons	251.00	300.00		49.00
Standing Committees				
Committee of Arrangements for Annual Meeting	3,189.20	4,000.00		810.80
Publications:				
A. *New England Journal of Medicine*	15,000.00	16,000.00		1,000.00
B. Annual Directory of Fellows	1,329.32	1,650.00		320.68
C. "Complete Catalogue of 1931"	1,783.45	1,400.00	383.45	
Membership and Finance	14.85	25.00		10.15
Ethics and Discipline	611.65	100.00	511.65	
Medical Education and Medical Diplomas		200.00		200.00
State and National Legislation	328.88	600.00		271.12
Public Health	19.50	100.00		80.50
Malpractice Defense	2,154.10	3,500.00		1,345.90
Special Committee				
Section of Obstetrics and Gynecology	193.30	250.00		56.70
Dividends to District Societies	4,000.00	4,000.00		
Contribution Boston Better Business Bureau	250.00		250.00	
Miscellaneous Expenses	35.19	75.00		39.81
Total	$43,969.53	$46,000.00		$2,030.47

APPENDIX NO. 2

REPORT OF COMMITTEE ON MEMBERSHIP AND FINANCE, ON FINANCE. BUDGET FOR 1932

Your Committee recommends the following Appropriations

Salaries:		
Secretary	$3,000	
Treasurer	500	
Assistant to President	2,500	
		$6,000

Expenses of Officers and Delegates:		
President and Vice-President	$500	
Secretary	850	
Treasurer	400	
District Treasurers	2,300	
Censors	700	
Delegates to House of Delegates, American Medical Association	1,200	
Delegates to New England Medical Council	150	
		6,100
Maintenance Society Headquarters, including clerical and other expenses		3,000
Shattuck Lecture		200
Cotting Luncheons		300
Standing Committees:		
Arrangements for Annual Meeting	$2,500	
Publications:		
a. *New England Journal of Medicine*	15,500	
b. Annual Directory of Fellows	1,650	
Membership and Finance	25	
Ethics and Discipline	25	
Medical Education and Medical Diplomas (including expenses of Delegate to annual Congress at Chicago)	200	
State and National Legislation (including expenses of Delegate to annual Congress at Chicago)	600	
Public Health	200	
Malpractice Defence	3,500	
		24,200
Special Committees:		
Section of Obstetrics and Gynecology	$250	
Public Relations	200	
		450
Dividends to District Societies		5,000
Total		$45,250
Estimated Income		$45,250

DAVID N. BLAKELY, *Chairman.*

APPENDIX NO. 3

REPORT OF COMMITTEE ON STATE AND NATIONAL LEGISLATION

Mr. President and Members of the Council:—

An effort to continue the work of general rural health and maternal and child health activities by means of federal aid was made at Washington by the introduction of Senate 572 and House 4739. These bills are known as the Jones-Cooper Bills and are intended to replace the Sheppard-Towner Act which legally ceased to function on June 30, 1929. Telegrams were sent to Senators David I. Walsh and Marcus A. Coolidge requesting that they use every effort in opposing these bills and satisfactory replies were received from them.

While fewer bills than usual were introduced for the consideration of the present session of the Legislature, we found no diminution in the number designed to influence the teaching and practicing of medicine.

HOUSE 73 is a petition asking that the present law governing the disposition of bodies of certain deceased persons be repealed. This would seriously handicap the anatomical departments of the medical schools, while SENATE 132 would likewise interfere with the teaching of physiology as the Anti-Vivisection Society asks for legislation to penalize operations on live dogs. We advised the defeat of these bills. They were given leave to withdraw.

HOUSE 264 asks for the establishment of State Medicine on war time principles. The bill is communistic in character and we opposed it. It was given leave to withdraw.

HOUSE 538 asks that physicians and surgeons be regulated in regard to operations and the disposal of organs and limbs removed at such times. We appeared in opposition. A similar bill was given leave to withdraw by the 1931 Legislature.

SENATE 35 is a petition asking for legislation to define the qualifications for membership in the Board of Registration in Medicine. The present Medical Practice Act by a strict interpretation does not permit the appointment of an osteopath, according to certain legal opinions. We did not appear at the hearing as we await the recommendation of the Council concerning the report of the committee appointed to study the various Medical Practice Acts.

HOUSE 60 asks that the Department of Public Health be directed to establish and maintain cancer clinics in various parts of the Commonwealth; while HOUSE 67 is comparable, asking that clinics and hospital facilities be provided for the care and treatment of persons suffering from rheumatism and kindred ailments. Nos. 60 and 67 were referred to the next annual session.

HOUSE 679 asks that the Department of Public Health maintain medical and health clinics at beach resorts in certain cities and towns.

HOUSE 929 asks for the establishment of the Massachusetts Medical Research Board for the purpose of studying and distributing certain facts and information. This bill was heard in 1931 and was referred to the present session. The object of the petitioner isn't clear and there is no demand by physicians or

scientists for the creation of such an institution by the State. We advise its defeat.

Your Committee awaits the action of the Council on the report of the Committee on Public Relations, that we may be properly instructed concerning the correct attitude to be taken toward public clinics and state research.

HOUSE 284 is a petition from Dr. Samuel B. Woodward for legislation to require the vaccination of children in private schools, while SENATE 201 asks that inoculation and vaccination be made voluntary and HOUSE 904 asks that the public be protected from impure vaccine. Dr. Woodward is to be commended for his patient efforts to save lives and his bill deserves our active support. It will be heard by the Committee on Public Health on February 25.

HOUSE 221 asks that certain precautions be required of pharmacists in dispensing prescriptions and then places this sentence in the bill—"No pharmacist shall change a prescription or substitute other ingredients for those specified, except with the knowledge and consent of the prescribing physician *if* said physician can possibly be reached." We oppose any substitution or change in a prescription *unless* the physician makes it.

HOUSE 906 and HOUSE 1084 asks that applications for registration as nurses be restricted to citizens of the United States and your Committee voted to oppose these bills, but not unanimously.

HOUSE 203 and HOUSE 204 are introduced by the Middlesex College of Medicine and Surgery, Inc. and by the University of Massachusetts, Inc. asking that they be authorized to confer the degrees of Doctor of Dental Medicine and Bachelor of Science respectively. We were present at the hearing of 204 on January 26 but did not ask to be recorded for or against this bill. House 203 will be heard on February 9.

HOUSE 593 is a petition from the State Executive Committee of the Socialist Party asking that a University of the Commonwealth of Massachusetts be established. This adds to the confusion of the universities.

HOUSE 188 asks that a board of examination and registration be established to regulate the practice of magnetic healers. The sole requirement for appointment to the board is—"Such persons shall be residents of this State, gifted with magnetic ability." We recommend the defeat of this bill.

HOUSE 226 a petition (initiative) for the passage of "An Act establishing a Board of Examination and Registration to Regulate the Practice of Chiropractic" was properly filed by ten qualified voters with the Secretary of the Commonwealth, with the requisite certificate of the Attorney-General attached, on October 23, 1931; and on December 2, 1931, 39,575 subsequent signatures of qualified voters had been filed.

Your Committee had an attorney, Lawrence B. Curtis of Mr. Dodge's office, procure a typewritten copy at once, that the construction of the petition might be studied for possible legal defects.

There were none. The bill in brief asks for the creation of a board of registration of three chiropractors. Chiropractic is defined as the science or practice of locating and adjusting by hand the malpositions of the articulations of the human spine. Chiropractors from other states, under certain conditions, may be registered without examination. In the event of death of a patient, under the care of a chiropractor, the said chiropractor shall call the medical examiner of the district where the death occurred.

Bills can be introduced for the consideration of the Legislature by a legislator or by an initiative petition of at least 20,000 signatures of legal voters, not more than 4,000 being obtained in any one county. If the petition is properly certified by the Attorney-General and the Secretary of State, it is assigned for a hearing. HOUSE 226 was assigned to the Committee on State Administration and the date of the hearing has been scheduled for March 2.

If the bill is passed by the Committee, House and Senate and is signed by the Governor, it becomes a law. If it is defeated in usual course, the petitioners are obliged to obtain 5,000 new signatures and deposit them for approval with the Secretary of State on or before the first Wednesday in August and the initiative will appear on the November ballot for the decision of the voters of Massachusetts.

The officers of the district societies and the members of the Auxiliary Committee have been supplied with this information and have been urged to oppose HOUSE 226 and to support certain important bills. The headquarters will gladly supply information on request that all may be properly informed concerning doubtful points.

There should be but one standard for the qualification of fitness to practice the healing art in this Commonwealth, namely, the passing of the examination given by the Board of Registration in Medicine.

The graduates of the regular schools, as well as the graduates of the Homeopathic and Osteopathic Schools, are obliged to pass this examination in order to be permitted to practice. The chiropractor may be registered likewise but he demands special privileges.

We advise the defeat of HOUSE 226.

Respectfully submitted,

SHIELDS WARREN,
Secretary of the Committee.

APPENDIX NO. 4

REPORT OF THE COMMITTEE ON PERMANENT HOME

Mr. President and Members of the Council:—

The Committee on Permanent Home was created by a vote of the Council on June 11, 1929. An active campaign was instituted and contributions were solicited from members of the Society throughout the State. About $19,000. was raised and deposited with the Treasurer as a building fund. Your committee served jointly with those representing the Academy of Medicine and the Boston Medical Library to solicit contributions from lay and medical friends for the United Building and Endowment Fund of the Boston Medical Library and the Massachusetts Medical Society. It was agreed that one-sixth of the net results would be allocated to the Massachusetts Medical Society.

At the meeting of the Council in June, 1931 a two-year note from April 1, 1931 from the Boston Medical Library to the Massachusetts Medical Society for $24,703.29 at 4½% interest was deposited with the Treasurer. This represented our share of the amount collected during the Campaign. A recommendation was made by your committee that the interest be added to the principal and the Council approved. The fund now totals about $47,000.00.

By authority of the Council, voted June 17, 1930, your committee was authorized to confer and agree with a committee from the Boston Medical Library upon the proportionate rate of maintenance for the space occupied at 8 The Fenway. This agreement was signed by both parties, December 1, 1931, and the offices of the Society and the editorial rooms of the *New England Journal of Medicine* are now satisfactorily located at this address.

A provision in the agreement permits the subject of proportionate cost of maintenance to be reviewed "prior to October 1, 1933". "This agreement shall continue until October 1, 1936. Unless notice in writing is given three months prior thereto of the desire of either party to terminate the agreement on said date, the agreement shall continue thereafter, but shall thereafter be terminable on either party giving the other three months' notice in writing."

As the Massachusetts Medical Society has not ac-

quired a permanent home; as a growing fund permits such a purchase when an opportune time presents itself; as some committee must continue this work, we respectfully recommend that this Committee be made a permanent one.

I hereby move that the Committee on Permanent Home for the Massachusetts Medical Society be made a standing committee and that an amendment to the By-Laws relating thereto be submitted to the Massachusetts Medical Society to be acted on at the annual meeting of the said Society, the said amendment to read as follows:

Chapter VII, Section 9. The Committee on Permanent Home shall consist of seven Fellows. It shall act for the Society in all matters pertaining to the financial and mechanical arrangements (of a temporary or permanent nature) necessary to secure and maintain adequate accommodations for the officers, employees and departments of the Society, subject to the approval of the Council.

It shall devise and execute plans for the raising of funds to be added to those which have been or may be acquired for the purpose of providing temporary or permanent accommodations for the Society.

All bills incurred shall be countersigned by the Chairman and forwarded to the President for his approval.

The Committee shall make a report of its doings to the Council including the condition of the fund for a home for the Society at the annual meeting of the Council.

Respectfully submitted,

THOMAS J. O'BRIEN,
Chairman.

APPENDIX NO. 5

REPORT OF COMMITTEE ON PUBLIC RELATIONS

Mr. President and Members of the Council:

This committee was created by the vote of the Council at the meeting held October 7, 1931 "that the Committee should be of a continuing character from year to year; that it should consider among other things the attitude of the various Public Health agencies toward the general practitioner".

It was voted that the Committee should consist of a member from each District Society with the President of the parent Society, ex officio, acting as Chairman. The members were to be appointed by the District Societies. In the event that a District Society does not hold a meeting previous to November 1, 1931, the President of the district was to appoint a member who shall hold office until confirmed by action of his society; that the Committee shall organize and make a first report to the Council at its meeting on February 3, 1932.

Meetings were held in Boston on December 8 and 29, 1931 and on January 22, 1932. The first meeting occupied over four hours, the second meeting five hours, and the third meeting four hours. At the first meeting the Chairman asked each member in turn to present his personal views and later they were discussed in a general way. Dr. George H. Bigelow, Commissioner of Health, was present as a guest at the second meeting and each member in turn was invited by the Chairman to question Dr. Bigelow concerning the public health problems. Dr. Bigelow answered the different questions and later made a résumé of the subjects explaining the status of his department. A unanimous vote of appreciation was extended to Dr. Bigelow by the Committee. At the meeting on January 22 the Chairman asked the Secretary to read the minutes of the previous meetings that the subject matter might be properly placed in the minds of the members of the Committee. The principles were discussed at length and the following motions were then made:

It was moved, seconded and passed that it is the sense of this Committee that the State Department of Public Health is encroaching, wittingly or unwittingly, upon the general practice of medicine.

It was moved, seconded and passed that a subcommittee of this Committee be appointed to confer with the "Public Health Council" with regard to the questions raised in this Committee and to assist the Department of Public Health that greater coöperation may be achieved with the general practitioner.

It was also moved, seconded and passed that this subcommittee be five in number and be appointed by the President. Dr. Stetson appointed Drs. W. A. Lane, H. W. Goodall, C. E. Mongan, J. H. Blaisdell and W. G. Curtis.

It was moved, seconded and passed that it is the opinion of this Committee that the State Department of Public Health should not establish further hospitals as for the care, treatment or research of chronic diseases, such as Diabetes, Heart Diseases, Arthritis, Nephritis or any chronic disease.

It was moved, seconded and passed that a copy of these resolutions be sent to each member of the Committee.

The Committee on Public Relations offers this report as one of progress and recommends that the work of the Committee be continued.

Respectfully submitted,

JOHN I. B. VAIL,
Secretary of the Committee.

Mr. President and Members of the Council:—

At a meeting of the Subcommittee, appointed by the Chairman of the Committee on Public Relations, held on January 29, 1932, the following resolutions were passed:

Resolved: It is the opinion of this committee that the establishment of hospitals and clinics by the Department of Public Health should not proceed further without consultation and coöperation with representatives of the Doctors of Medicine, licensed to practice in this Commonwealth.

Resolved: This committee is opposed to House bills 60, 67, 679 and 929.

Resolved: The time has arrived when the Massachusetts Medical Society should start a system of postgraduate instruction.

Respectfully submitted,

W. G. CURTIS,
Secretary of the Subcommittee of the Committee on Public Relations.

NEW ENGLAND SURGICAL SOCIETY

UMBILICAL HERNIA*

BY RICHARD H. MILLER, M.D.†

UMBILICAL hernia, simple or strangulated, constitutes a subject about which one today hears little discussion and reads still less. As this condition, however, is one which is constantly being seen in any large clinic, and as it is responsible for a certain number of deaths, it has seemed wise to present to you the results of a study of a number of cases which have entered the Massachusetts General Hospital in recent years. The author's attention has been particularly attracted to the matter by two facts: first, that simple umbilical hernia has been so generally looked on as a rather harmless condition, and yet, secondly, that patients so often come to the hospital, with strangulated umbilical hernia, in a most precarious or even dying condition. It seemed hard to reconcile the complacency, with which the profession has viewed the simple hernia, with the apparent high incidence and equally apparent danger of the strangulation.

The object of this paper is to present figures showing the frequency of the lesion in our Clinic, also the incidence of strangulation; then to draw certain conclusions concerning the probabilities as to what will happen in a given number of cases. There will be no attempt to discuss the technique of operative procedures. The routine operation for simple hernia, described by Mayo, cannot be improved upon, and the proper handling of severe strangulations is a variable and difficult matter, the discussion of which would lead us into considerations of intestinal obstruction and intestinal resection. A search of recent literature has failed to reveal any articles bearing particularly on the subject in hand.

TABLE I

UMBILICAL HERNIA

1911-1930

Total Cases 349

Simple	289 (83%)	Strangulated	60 (17%)
Deaths	7	Deaths	18
Mortality	2.4%	Mortality	30%

The figures and conclusions here to be presented can most concisely and clearly be given in a series of tables which are, as will be seen, self-explanatory. Table I represents all the cases admitted for 20 years, 1911 to 1930 inclusive. The outstanding facts in this are first that 17% of all admissions of umbilical hernia are cases of strangulation, and secondly, that the mortality in the simple group is only 2.4%, while that in the strangulations is 30%.

Table II is similar, but represents a period of only 10 years, and it is striking that the proportion of simple to strangulated cases is precisely the same as in Table I. It is from this second group that the cases have been selected for particular study. The mortality figures are extraordinarily similar.

TABLE II

UMBILICAL HERNIA

1921-1930

Total Cases 223

Simple	185 (83%)	Strangulated	38 (17%)
Deaths	6	Deaths	12
Mortality	3%	Mortality	31%

Table III represents the first analysis of the strangulated cases in the ten-year period. As one would expect, the morbidity in females is double that in males, and the average age is that of an advanced group. It is to be noted that one case was in an infant, but this is a most unusual event, and the age figure was computed without including it.

TABLE III

STRANGULATED UMBILICAL HERNIA

38 Cases

Male	9—31%
Female	29—69%
Average age 37 cases	59
1 case aet.	2

A study of the deaths from strangulation is seen in Table IV, and the surprising predominance of the females over the males is noteworthy, although probably more or less of a coincidence. Eight of the 12 had had symptoms for more than 3 days before admission, which is consonant with our idea of the probabilities.

Table V, showing the length of life after admission, demonstrates that two-thirds were in such condition that, in spite of the best and most carefully selected treatment, they failed to survive more than 24 hours.

The causes of death, represented below, are given as accurately as could be stated. The

*Read at the annual meeting of the New England Surgical Society, Portland, Maine, September 12, 1931.

†Miller—Assistant Professor of Surgery, Harvard Medical School. For record and address of author see "This Week's Issue," page 409.

fact that 6 deaths, or one-half of the total, were due to toxemia, operation and shock, impresses one still further with the very serious condition in which the patients are found on their admission to the hospital.

TABLE IV

DEATHS FROM STRANGULATED UMBILICAL HERNIA

12 Cases out of 38

Female 11—Male 1

Average Age 61

Duration of Symptoms

Days	
0-1	4
1-2	0
2-3	0
3-4	2
4-	6

TABLE V

STRANGULATED UMBILICAL HERNIA

12 Deaths

Length of Life After Admission

Days	
0-1	8
1-2	2
2-3	
3-4	
4+	2

TABLE VI

STRANGULATED UMBILICAL HERNIA

Causes of Death

12 Cases

Operation, Shock, Toxemia	6
Pulmonary	2
Cardiac	2
Peritonitis	1
Miscellaneous	1

In the 12 cases of death 11 had an immediate surgical operation, and the twelfth, considered too sick for any surgical intervention, died in 8 hours. Local anesthesia was employed 5 times, ether 5 times, and ethylene once.

If the above figures may be taken as a sound basis from which to draw conclusions, the following deductions may be obtained:

1. Of simple umbilical hernias, 17% or one in every 6, will strangulate.
2. Of strangulated umbilical hernias 30%, or one in almost every 3, will die.
3. Every case of simple umbilical hernia has one chance in 6 of strangulation, and one chance in 18 of dying of the hernia.
4. The operation for simple umbilical hernia presents a mortality of slightly under 3%, or about one case in 33.
5. Operation of election for simple hernia is safer than scientific expectancy, and therefore operation should always be urged in preference to the use of mechanical supports.

DISCUSSION

DR. W. C. SEELYE, Worcester, Mass.: The high mortality of strangulation accentuates the importance of operation in these cases early, as Dr. Miller has brought out. It has been my experience that most of the cases of strangulation are of heavy, fat women who are poor operative risks, and in almost every instance they have had an umbilical hernia for from fifteen to twenty years and have come in with strangulation, when they might so much better have been operated upon before strangulation occurred.

I heartily agree with Dr. Miller in the importance of operating on the umbilical hernia cases early before they have arrived at that stage. I think with very few exceptions such cases should be operated upon as early as the umbilical hernia has appeared in order to avoid the subsequent consequences of the strangulation and the high mortality which results.

I should like to add a word as to the technique which I am most fond of in the operation. It is a low transverse incision, pulling the hernia mass upward and bringing the incision through the skin entirely below the hernia, and then dissecting straightway down to the ring without entering the hernia at all, until the ring is entirely exposed; then entering the hernial sac exactly at the ring, thereby dissecting backward and opening the sac from below upward, having at that time merely opened the ring sufficiently to give room for reduction of the hernia. In that way the sac can be exposed in the quickest possible way by working from below upward and the whole hernial sac can be entered without any danger of cutting through the skin into the bowel. The whole operation can be done in a very speedy manner by the approach from below at the margin of the ring.

DR. D. C. PATTERSON, Bridgeport, Conn.: I have been much interested in Dr. Miller's paper because I had not realized before the high incidence of strangulation in cases of umbilical hernia. According to his findings it is 17 per cent. This danger, taken with the high mortality of 31 per cent. in cases of strangulation, surely justified Dr. Miller's plea for an elective operation.

Personally I would advise operation in any adult case with a protrusion of any size or symptoms that might be attributed to the hernia. Of course, you see a good many cases in which there is just a mere defect the size of the finger. These patients very rarely have symptoms and I

think that it is not necessary or justifiable to submit them to operation.

Of course all cases of strangulation demand immediate interference. A good many of the simple cases rarely come to the hospital on account of the hernia, but for some other condition and the small hernia is discovered during the course of the examination. The ones that do come to have the hernia repaired are generally advanced cases with adherent omentum causing discomfort, and these patients are usually such poor operative risks that we advise treatment with a proper support. If they are at all operable, I think they should be operated on.

Children present a different problem. Many of the children have had their hernias protracted through the practice of putting a button over the navel and strapping it down with adhesive plaster. It merely presses in and separates the muscles more than ever. A plain adhesive strip is all that should be applied. If the hernia persists in children after the age of five or six, I think it should be repaired.

Dr. Miller mentioned in his paper, but not in his remarks, that the Mayo operation could not be improved upon. There are times, however, when the repair is carried out in addition to some other abdominal procedure, either in the pelvis or many times on the gallbladder. The longitudinal incision is then the one of choice.

In children I always make it a practice to preserve the umbilicus. It is easily done and may save the patient some embarrassment in later life.

Dr. David Cheever, Boston, Mass.: I want to express my entire approval of the very sound doctrine propounded by Dr. Miller, Dr. Seelye, and Dr. Patterson.

I want to add a historical note which has a bearing on the story of umbilical hernia at the Massachusetts General Hospital. I believe that the first successful laparotomy performed there was on a patient with strangulated umbilical hernia, performed by the late Dr. Arthur T. Cabot in 1874 when he was a very young man. The story as I have heard it is that the late Dr. Henry J. Bigelow was in charge of the service assisted by his younger associate, Dr. Richard M. Hodges. Dr. Cabot was, I presume, a surgeon to out-patients and he saw the patient on admission and reported to his seniors, one of whom, I believe, was busy with some social engagement and the other ill. Dr. Cabot said he would like to operate on the patient—a thing which was apparently scarcely thought of in those days,—and was given permission to go ahead. The operation was performed and the patient made a good recovery.

Dr. P. E. Truesdale, Fall River, Mass.: In the strangulated type of umbilical hernia our mortality has been over 30 per cent., but I want to suggest the use of a two-stage operation for this condition. In the first place cutting the ring under local anesthesia, on one side only, allowing the circulation to be reëstablished, and at a later time doing the reduction and cure of the hernia.

Dr. George A. Moore, Brockton, Mass.: I would like to emphasize one aspect of this subject, which Dr. Miller has touched upon in his very efficient presentation. Most patients with umbilical hernias are fat, flabby individuals with myocarditis and low kidney function, who are poor surgical risks, even before strangulation occurs. The most important part of their treatment is not the operative technic but the preoperative and postoperative care. This fact has been emphasized by the staff at the Mayo Clinic and its acceptance is of great aid in handling these cases.

Dr. R. H. Miller: I purposely did not try to discuss the matter of the technique of operation on strangulated hernias because that would lead us at once into the matter of obstruction and intestinal resection, but I think that what Dr. Truesdale said is very valuable, as he infers by just one sentence that you must be very careful and guarded in your handling of strangulation, that often you cannot go ahead and do radical resection and big operations, because the patient cannot stand them.

One reason why we have had such a high mortality at our hospital is that the men have tried to do too much in the way of resection, and that sort of thing. I know I did before I learned to be a little slower and more thoughtful in my treatment.

Thank you very much.

A PLAN FOR THE MANAGEMENT OF ARTHRITIS IN LARGE COMMUNITIES

BY FRANK R. OBER, M.D.*

CHRONIC arthritis is a disease affecting a large part of our population. Dr. George H. Bigelow, State Commissioner of Health in Massachusetts, reports with Dr. Herbert L. Lombard[1], that there are 145,000 arthritics in Massachusetts. These figures are probably too low because the diagnosis is frequently not made early or its early manifestations are often not appreciated. The social and economic disturbances resulting from such a high incidence of one type of disease process, which too often leads to more or less crippling, must be very tremendous in the aggregate.

The question arises, are our present methods of attacking this problem adequate and is there any important headway being made towards solving this tremendous problem? The answer is no.

In all fairness, however, it must be conceded that there are better results in this disease than there were ten years ago, because more physicians are becoming interested in treating arthritis, but general interest among the medical profession is still lacking to a great degree.

There are reports of cures as a result of removing foci of infection, the use of vaccines, the removal of thyroid glands, the reduction of starches and sugars in diets, the administering of numberless drugs by mouth, rectum and intravenously, nostrums, etc., ad infinitum. In spite of all the "wonderful" remedies and methods, about which one hears, there still remains a vast number of arthritics who have tried all the above, but still the arthritic process goes merrily on from bad to worse. One does see at times, what seems to be a miraculous result from the removal of a dead tooth, or an infected tonsil, or from vaccines, but what of those who are made worse by the use of vaccines, sera, etc., or who progress steadily downhill after removing foci of infection or the injections of drugs, or who do not respond to changes in diet. Will we ever get anywhere in this huge problem by attacking a few isolated individuals by such divergent methods? The answer to this is no. The *remedy* is *coöperation*. The patient himself must have an early diagnosis and he must be cared for in a meticulous manner, and whole-hearted attention must be given to every aspect of the patient's case. *We must cease to think of him as a home for bacteria; we must think of him as an organism who eats, drinks, and lives as he chooses, frequently without thought as to what is happening to his body and health.*

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The joint condition in arthritis is merely a local manifestation of a constitutional disease, and there are many factors entering into its causes and occurrence in the individual. It would then seem to be fairly obvious that large masses of arthritics should be studied individually, in order to secure and compile information that will be of real value in relieving these patients, since many of us know that they do not all respond to any one method of treatment.

Infantile paralysis is not more crippling than arthritis, and its cause has not been found, but, since the organization and operation of the so-called Vermont Plan by Dr. R. W. Lovett in 1914[2], there has been a marked reduction in the total amount of crippling, permanent and partial, in this disease which is so dreaded. This plan in operation is simple, relatively inexpensive, and furnishes expert treatment to every one, and, at the same time, investigative studies are being carried on which lead to valuable information.

Dr. Elliott P. Joslin[3], with his few wandering nurses is able to care for a large number of diabetics at a low cost with great benefit to many individuals.

Hospitalization to take the place of the above two plans would be out of the question: first, because the patients for the most part are better off at home; secondly, there are not enough hospital beds to keep a large number of such patients for an indefinite period; and, thirdly, the financial burden would be too great to be borne by the patients and the public. Arthritis, which is both a medical and a surgical problem, can be handled with greater benefit to a larger number of sufferers than is now being done if both hospitalization and organized care at home and in out-patient clinics are utilized in a coördinated and coöperative way. At present it is especially difficult to secure beds for even a few arthritics, and these patients naturally think that they are not wanted, so they lose hope and suffer accordingly.

There are then two plans of organization for the care of chronic arthritis.

1. The establishing of enough hospitals to take care of all arthritics

or

2. The establishing of one hospital combined with field work.

Under the first plan the patients would probably receive exquisite care at a high cost, but which would result in a total loss for the lack of adequate follow-up treatment at home, which

is so very necessary in any crippling disease. Under the second plan, the patient would receive a minimum of hospital care and a maximum of after care. This should result in better knowledge to the doctors, nurses, physiotherapists, and thus better treatment for the patients.

This second plan may be outlined as follows:

ORGANIZED PLAN FOR THE CARE OF THE ARTHRITIC

Central Hospital
200-250 Beds
1 Superintendent
1 Director

Clinical Force

Physicians
Surgeons
Dentists
Nurses
Physiotherapists
Occupational Therapists

All trained in the care of arthritic patients

Hospital School to Educate
Physicians and Surgeons
Nurses
Physiotherapists
Occupational Therapists

Research Department
Clinical
Pathological
Chemical
Bacteriological
Biological
Climatological
Psychiatric
Sociological
Economic

Mobile Units for Study, Diagnosis, Treatment and Survey—Made up of
1 Director
Physicians and Assistants
Orthopedic Surgeons and Assistants
Secretaries and Stenographers
Nurses
Physiotherapists

Follow-up care should be carried on by members of the mobile units. This is one of the important and necessary features of the whole scheme, if it is to be a success. These workers should give instruction and care in the homes after the patients have been sent out of the hospital or after they have been seen in the mobile clinic.

The patient's personal physician must be included in the above scheme, and he should have all the benefits of coöperation in the treatment of his patients.

A council or committee on arthritis should be set up to manage such a plan and secure funds.

The key of study and treatment is education of the patient, family, doctor, and nurse.

The author wishes to express his thanks for kindly assistance in the preparation of this article by Dr. George R. Minot.

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END-RESULTS IN A SERIES OF SIXTEEN CASES OF FIBROSARCOMA

BY R. W. FRENCH, M.D.*

THE purpose of this paper is to report a study of sixteen cases of fibrosarcoma recorded at the Truesdale Hospital since 1918 in order to estimate the percentage of recurrence, and ascertain the duration of life after operation. It was felt that the results of treatment among patients suffering from fibrosarcoma could be determined best by dividing the sarcomata into three groups according to the degree of malignancy present, and correlating each type with the length of time the patient lived. The only tumors under consideration are the fibrosarcomata which arise from fibrous connective tissue. After excluding the chondrosarcomata and osteogenetic sarcomata, sixteen cases of fibrosarcoma remain for consideration. Fourteen patients were operated upon. There were three recurrent cases. In only one case did the patient attribute the cause of the tumor to trauma.

Biopsy was done preliminary to operation in three cases. In one instance an exploratory laparotomy revealed the tumor to be inoperable. Biopsy confirmed the diagnosis. In the second case a preliminary biopsy was done before a thigh amputation. In a third case diagnosed clinically as osteomyelitis and treated by incision and drainage, biopsy established the diagnosis before amputation of the thigh was undertaken. This is worthy of mention since occasionally there is a tendency to dispense with biopsy and depend entirely on clinical and x-ray diagnosis of fibrosarcoma. It is felt that the exploratory operation is attended with considerable risk of infection; that, if the tumor is highly malignant, the disease may become more quickly generalized. We have not had infection after biopsy and the intervals between biopsy and amputation have been kept short so as to forestall extension of the tumor.

Love's[1] experiments with Jensen's fibrosarcoma in rats indicate that (1) the frequency of cellular division is in proportion to the rapidity of the growth of the tumor; (2) the dura-

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tion of the cellular division has no effect on the rapidity of the growth of the tumor; (3) variations in the rapidity of growth of different tumors of the same kind depend exclusively upon modifications in the duration of the intermitotic period. Broders[2] in his study of the microscopic cellular pathology of growths in 1,628 patients learned that carcinoma varies greatly in malignancy, its nature depending on the cells which compose it as well as the stage of its development. The percentage of mitotic figures gave a reliable index of the degree of malignancy.

This principle holds for the fibrosarcoma in our series. The greater the amount of nuclear material in proportion to the cytoplasm, the more rapid was the mitosis and the more malignant the growth. Usually the result of operation depended upon the degree of malignancy of the tumor process and not upon the extent or duration of the condition.

Although all degrees of malignancy existed, the fibrosarcomata in this series can be roughly classified in three groups according to the histologic differentiation. The tumors of first-degree malignancy contained spindle cells in a dense stroma of fibrous material with abundant stroma and few cells. Second-degree malignant tumors showed less intercellular substance with large spindle cells in compact intertwining bundles predominating. Tumors of third-degree malignancy had a very cellular structure made up of embryonic fibroblasts with very little stroma. In all cases but one the prognosis could be predicted from the laboratory analysis,

Case	Year of admission	Sex	Age	Time in Hospital	Symptoms	Duration of Symptoms	Site	Biopsy	Treatment	Type of Malignancy	End results
1	1910	Female	40 yrs.	18 days	Leg swollen Pain in leg and cecum.	4 mos.	Retro-peritoneal	Yes	Exploratory Inoperable	3rd degree	Died 6 mos. later
2	1918	Male	67 yrs.	3 days	Painless lump in left chest (recurrent)	10 mos.	Left chest wall	No	Wide excision	2nd degree	Recurrent 7 years later
	1925		74 yrs.	4 days	Painless lump in left chest (recurrent)	2 mos.	Left chest wall	No	Wide excision	2nd degree	Recurrent 16 mos. later
	1926		75 yrs.	7 days	Painless lump in left chest (recurrent)	6 mos.	Left chest wall	No	Wide excision	3rd degree	Recurrent 15 mos. later
	1927		76 yrs.	8 days	Painless lump in left chest (recurrent) Burning dead sensation in left arm.	7 mos.	Left chest wall	No	Wide excision	3rd degree	Died 1 year after operation
3	1918	Male	41 yrs.	44 days	Pain in left hip	3 mos.	Left thigh	No	Inoperable	3rd degree	Died 2 mos. later
4	1921	Female	47 yrs.	5 days	Pain and numbness in left elbow	27 yrs.	Left arm	No	Wide excision	1st degree	Recurrent 11 mos. later
	1922		48 yrs.	6 days	Painless swelling in left arm.	6 mos.	Left arm	No	Wide excision	1st degree	No recurrence Died of pneumonia Feb. 7, 1924
5	1921	Male	47 yrs.	10 days	Large multiple painless swellings in right groin	10 yrs.	Right groin	No	Excision	No malignancy Hyperfibroma	No recurrence
	1929		55 yrs.	5 days	Painless swelling in right sub-glutteal region.	7 yrs.	Right subgluteal region.	No	Excision	1st degree	Recurrent 2 years later.
	1931		57 yrs.	5 days	Painless swelling in right sub-glutteal region.	1 yr.	Right subgluteal region	No	Excision	1st degree	Left hospital well. Too soon to state end results.
6	1923	Male	31 yrs.	6 days	Pain in left antrum after tooth extraction.	1 mo.	Left cheek	No	Wide excision	3rd degree	Reentry one month later for coelerization of fibrosarcoma. Died 6 mos. later.
7	1925	Female	73 yrs.	69 days	Pain in abdomen	10 days	Uterus	No	Pan-hysterectomy, radium.	3rd degree	Coincident with carcinoma of vaginal wall. Died 7 mos. after operation.
8	1925	Female	47 yrs.	53 days	Pain in right thigh	6 mos.	Right thigh	Yes	Amputation of rt. thigh	1st degree	No recurrence. Well and free of disease 6 years later.
9	1926	Male	62 yrs.	20 days	Fracture of right clavicle	6 wks.	Right clavicle	No	Excision	2nd degree	Died 2 mos. after operation.
10	1928	Female	58 yrs.	11 days	Painless slow-growing lump	For yrs.	Abdominal wall, rt. l. quadrant	No	Wide excision	1st degree	No recurrence. Well and free of disease 5 years later.
11	1928	Female	44 yrs.	24 days	Cough and abdominal pain.	2 mos.	Round ligament	No	Pan-hysterectomy	1st degree	Multiple fibroids, retroperitoneal tumor. Recurrence 6 mos. later. Refused operation.
12	1929	Female	2 yrs.	18 days	Gradual swelling of left tibia.	2 mos.	Left tibia	No	Left thigh amputation	3rd degree	No recurrence. Well and free of disease 2 years later.
13	1930	Female	43 yrs.	17 days	Intermittent pain in rt. upper quadrant	1 yr.	Abdominal wall, rt. u. quadrant	No	Wide excision	1st degree	No recurrence. Well and free of disease 1 year later.
14	1931	Female	48 yrs.	16 days	Pain in right and left upper quadrant	1 yr	Ovary	No	Pan-hysterectomy	2nd degree	Alive and well 5 mos. after operation, coincident with intrauterine myoma.
15	1931	Female	14 yrs.	22 days	Recurrent pain in region of scar, rt. scapula swelling	2 mos	Chest wall	No	Wide excision	1st degree	Alive and well 2 mos. after operation.
16	1931	Male	53 yrs.	18 days	Swelling on dorsum of rt. foot	2 mos.	Right foot	Yes	Thigh amputation	2nd degree	Alive and well 2 mos. after operation.

the highly malignant forms recurring rapidly with brief postoperative survival of the patient. No operative deaths occurred.

Information as to the end-result was secured regarding all sixteen patients, usually from the physician sending the patient to the hospital for operation. Ten of the patients were female, six, male. The ages ranged from 2 to 76 years, the average age being 44.7 years. The average length of time spent in the hospital was 17 days. With the exception of two cases, the symptoms were present for not more than a year prior to admission to the hospital, pain and swelling being the most constant symptoms. For the most malignant type of tumor the average length of time of postoperative survival was 7.4 months with the exception of a two-year-old girl who is alive and well without signs of recurrence two years after operation. In the case of a man who had three recurrences, a tumor of second-degree malignancy first recurred 7 years after operation and again recurred 14 months later. At this time the microscopic examination showed that the tumor had changed histologically to the most malignant type. It recurred a third time a year later. The patient died two months after operation.

Another patient was operated upon in 1921 for recurrent multiple myxofibromata of the right groin, which according to the history had been growing slowly for 14 years following the first excision in 1907. Less than a year after this operation a small tumor appeared at the same site and began to grow steadily. During 1924 the patient was given x-ray treatment. Six months later an ulcer appeared at the tumor site and healed slowly. In March, 1929, a tumor appeared in the subgluteal region and was removed six months later. The growth measured 4 x 5 x 5 cm. Microscopic examination revealed a fibrosarcoma of low-grade malignancy. It recurred a year later and grew steadily to the size of a walnut. In August, 1931, the patient returned to the hospital. The neoplasm was excised. Laboratory examination showed it to be a fibrosarcoma of low-grade malignancy, somewhat more cellular than the specimen removed in 1929.

In a woman 47 years of age, there was recurrence of a first-degree malignant tumor eleven months after operation. The tumor was again excised. This patient died three years later from pneumonia. At this time examination failed to show recurrence.

In two cases exploratory laparotomy revealed the tumor to be extra-peritoneal and inoperable. In one case with recurrence of a neoplasm of low-grade malignancy the treatment was x-ray irradiation followed by excision. Radium was given in one case in which the growth was of third-degree malignancy. In all other cases the treatment was surgical, either amputation or wide local excision.

The end-results are determined by the degree of malignancy in most instances. One patient is well with no sign of metastasis six years after operation, another, three years, and a third, one year. All three had sarcomata of low-degree malignancy. In the three 1931 cases, the operations are too recent to estimate end-results. Yet this review demonstrates that a detailed pathologic description is essential to any report of end-results in fibrosarcoma. Aside from palliation of symptoms, in cases where the tumor is strikingly malignant the patient has little chance of long postoperative survival following radical operation. The few cases in which the patients are still alive, however, furnish adequate testimony as to the advisability of early and radical excision of the tumor.

The subcutaneous and intermuscular tissues are the favorite sites of fibrosarcoma. Six in our series occurred in the extremities, five in the chest and the abdominal walls, three in the uterus, the ovary, and the round ligament, and one in the left cheek. The recurrences were in the chest wall, the thigh, and the left arm. None of the neoplasms appeared to be slow-growing. The most surprising end-result was observed in a two-year-old patient. Considering the type of malignancy and age of the patient, the prognosis was very poor; yet the postoperative survival is two years with no sign of recurrence. Undoubtedly this tumor must be classified as an undifferentiated round-cell sarcoma, which, according to Phemister[3], offers a more favorable prognosis than its histology would lead one to suppose. Phemister has assembled five cases of undifferentiated round-cell sarcoma in which cures lasting from five to ten years have been obtained, although all had a very cellular structure and were almost devoid of stroma. One tumor was treated by irradiation only, one by amputation, and three by both irradiation and local excision.

From a general survey of the literature regarding end-results in cases where radium is used, it may be assumed that fibrosarcomata are radio-resistant to a high degree and tend to metastasize rapidly[4]. Postoperative radiation is effective in some cases. In general, surgical treatment with wide excision is indicated in all operable cases. Moreover, in fibrosarcoma of the thigh, amputation is preferable to radiation alone or local excision. Radium was employed in only one case in our series. To be effective it should be instituted soon after excision and the entire operative area radiated before the formation of scar tissue.

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TWO CASES OF ATYPICAL FAMILIAL DYSTROPHY*

BY GARRY DE N. HOUGH, M.D.†

THE two children, Kathleen and Justin D., whose histories are herewith reported were born in Springfield, Mass., on January 27, 1914 and August 28, 1916, respectively, of Irish-American parentage. They were the first two children of the family. Subsequently there were three others—Janet, born in 1918; David, born in 1920, and Margaret Anne, born in 1928; these three children are normal and healthy.

Both parents were physically normal in every respect. In response to repeated questioning the father recollected that when playing as catcher on a baseball team as a young man, he had difficulty in assuming the usual squatting position. Examination at the present time fails to disclose any abnormality. There is no other suggestive family history. The father is one of two sons, his brother and nephew being entirely normal. The mother has two sisters and one brother with six children, all of whom are normal.

Kathleen was born at full term and delivered without operation after a normal labor. There was no difficulty in establishing respiration. She was healthy and normal during infancy and early childhood. She had measles at three years, and whooping cough at five; her tonsils and adenoids were removed at six years and she had chicken pox at ten years of age. All of these illnesses were without complication. There was no history of any acute illness suggestive of anterior poliomyelitis. At seven years of age a beginning equinus deformity of the left foot was noted. At first this was observed subjectively when attempting to run. This deformity gradually increased, and after two years, at the age of 9, the same condition appeared in the right foot. About one year later the deformity became so severe that the weight was borne on the metatarsal heads. There was considerable difficulty in maintaining balance and she fell frequently. Walking relatively short distances produced considerable fatigue. She had massage treatments under the direction of a well-trained physiotherapist, and a few osteopathic treatments without relief.

She came under our observation in October, 1925, and admission to the hospital was recommended, but because of the length of the waiting list, this was impossible until October, 1926. Physical examination then showed a slender, fairly well-nourished girl of 12 years, standing with both feet in marked equinus, the dorsum of the feet being in line with the anterior tibial surface. There was fairly extreme lumbar lordosis, and abdominal protuberance. There was moderate upper dorsal kyphosis and the scapulae were prominent. There was no abnormal facies and the head was apparently normal. The cranial nerves showed no abnormality. General examination of heart, lungs and abdomen showed no evidence of any pathology. The abdominal reflexes were present and normal. There was no paralysis in any part of the body, and the hips and knees both showed good strength. The dorsiflexors of the feet were present and apparently strong, but there was no active dorsiflexion. Passive dorsiflexion was limited at 160°, apparently solely by the marked contracture of the calf groups. X-ray examination of the feet was negative except for the extreme deformity. Roentgenograms of the chest and spine showed no abnormality. Urinalysis was normal at two examinations. A vaginal smear and the von Pirquet test were negative. The blood showed a coagulation time of 8½ minutes; hemoglobin 73%; red blood cells of 5,100,000 and white cells of 9,700, with a differential count of 61% polymorphonuclear neutrophiles, 35% lymphocytes and 4% large mononuclears.

On October 28, 1926 tendon lengthening of both Achilles tendons was carried out under ether anesthesia. The tendons were lengthened approximately 2 inches, permitting dorsiflexion to slightly above a right angle. The sliding technic was used and on the right a complete separation of the fragments was inadvertently obtained, which was sutured with No. 0 chromic catgut. The wounds were closed and long leg plaster casings applied with the feet at 90° dorsiflexion. The patient was discharged from the hospital in plaster, which was removed in the out-patient department after 4 weeks. The wounds were then well healed and weight-bearing in short leg plasters was instituted. Two weeks later these plasters were bivalved for night wear and activity allowed without support during the day.

In March, 1927, three months after operation, the child was walking easily with practically normal gait. The correction of equinus had been maintained and the anterior tibials showed normal activity and strength. Both calves were weak, the right more than the left. The knee jerks at this time were normal. Special exercises to strengthen the calf muscle were started, and after three months good strength was present.

In September, 1927, a year after operation, the general picture was more suggestive of a muscular dystrophy. The equinus had remained corrected, but the lordosis was marked, and the gait was unsteady, with outward rotation of both legs. She was unable to rise from a chair without the use of her hands, and in standing from recumbency there was a suggestion of "climbing up the legs".

In May, 1928 a progressive increase of lumbar lordosis and a fairly marked side-to-side sway in her gait were noted. Disability had not increased, and there was no relaxation of the shoulder girdle. A Goldthwait back brace was applied at this time.

In November, 1928 loss of power in the glutei was noted, and loss of ability to walk upstairs; otherwise there was no change. Progressive disability and the continued advance of symptoms led me, in May, 1929, to feel definitely that the condition was a slowly progressive muscular dystrophy, without pseudohypertrophy. The gait was worse, and the lumbar lordosis had increased to such an extent that the Goldthwait back brace could no longer be worn. The quadriceps were just able to hold against gravity. There was slight, but definite, shoulder girdle relaxation, and the pathognomonic Gowers's sign of "climbing up the legs" was present.

However, after a summer spent in outdoor life with a considerable amount of swimming, the patient presented definite improvement. The muscle strength was greater throughout; the gait was improved; and the patellar reflex was present bilaterally with reinforcement. This improvement was maintained and in September, 1930, at the age of 16 years, she was definitely better than one year before. She walked easily with a moderate side-to-side sway, but was unable to get upstairs without a hand rail, and could not run. The arms were strong and only a slight looseness of the shoulder

*In a series of thirty cases of progressive pseudohypertrophic muscular dystrophy recently reported from the Shriner's Hospital for Crippled Children, Springfield, Mass.[1], every case conformed fairly closely to the characteristic type described by Duchenne. The two cases which are reported here are the only other cases of dystrophy seen at this hospital during the same period.

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girdle could be detected. The hips showed weak flexor muscles, very little power in the extensors, none in the adductors, and poor power in the abductors. The hamstrings could act against gravity, but not against resistance, and the quadriceps held against slight resistance. The erector spinae group was strong and the abdominals of good tone, although unable to lift the body from the prone position.

On March 21, 1931, the ability to get about was the same; the girl walked with a marked side-to-side sway and there was extreme lumbar lordosis. She was unable to step up high steps, such as boarding a street car, and climbed up sidewise. She could elevate the arms to 70° from the vertical plane with difficulty; the biceps on the right was poor and on the left held against slight resistance. She was unable to raise either leg against gravity, but otherwise the leg muscles were the same. She still "climbed up her legs" in the characteristic manner.

From March to September, 1931, she was given daily injections of pilocarpine and adrenalin, after the method described by Kuré and Okinaka[2] and recently reported from this clinic. A total of ninety injections was given, with a two weeks' interruption following each thirty treatments. So far as could be seen, there was absolutely no change in the condition. The patient still has the same difficulty in going upstairs and in taking a high step, such as getting into a street car. She still requires use of her hands to arise from a sitting posture and presents a marked lumbar lordosis, a swaying gait, and considerable muscle weakness. However, as she approaches her eighteenth birthday she is obviously in far better condition than most patients with progressive muscular dystrophy.

On December 10, 1930, Justin, the second child, was seen with a complaint similar to that of his sister. He was born August 28, 1916, at full term and with normal delivery. His childhood had been uneventful, except for measles and mumps. His father first noted a difficulty in gait during the summer of 1929, when he and his son were mountain climbing. The boy, however, stated that he had experienced difficulty going upstairs since 1927 and had not been able to stand on his heels for some time. He had said nothing about this because he recognized it as the same difficulty his sister had, and he did not want to distress his parents. The condition had been getting worse, and when seen his knees frequently gave way on trying to run, and he had some difficulty in getting up from a chair.

Physical examination showed a thin, small boy of 14 years, with a marked facial resemblance to his sister, Kathleen. The question of family resemblance was gone into and the parents were uncertain as to whom these two children resembled. They are not particularly like either parent, and are distinctly different from the three younger children. Justin stood and walked with marked bilateral equinus, moderate exaggeration of lumbar lordosis, slight abdominal prominence, and markedly prominent scapulae. He was bright and coöperative. General examination of the heart, lungs, and abdomen was negative, except for a mild sinus arrhythmia. There was no relaxation of the shoulder girdles. The muscles of the arms were relatively weak, but acted against moderate resistance. The abdominals raised the body from a supine position with a little assistance. Both adductors and quadriceps showed some definite weakness, and the dorsiflexors of the feet were below normal strength, although active. The knee jerks were diminished bilaterally. Both feet showed a fixed equinus of about 130°, apparently solely due to contracture of the calf groups. The right calf and the left quadriceps presented localized pseudohypertrophic areas. He "climbed up his legs" on getting up from the floor in the typical manner described by Gowers.

He was admitted to the Shriner's Hospital February 16, 1931. Urinalysis was negative at 3 examinations. The blood coagulation time was 4 minutes; the hemoglobin was 80%, the red blood cells 6,250,000; the white count was 9,600 with 50% polymorphonuclear neutrophiles, 6% eosinophiles, 37% lymphocytes, and 7% large mononuclears. The von Pirquet test showed a slight transient reaction to the human tuberculin, disappearing in 48 hours, and negative to the bovine.

On February 19, 1931, a bilateral lengthening of the Achilles tendon was done under ether anesthesia. The muscle was exposed at the musculotendinous junction and a small section removed for microscopic study. Examination by Dr. J. Albert Key, director of research of the Shriner's Hospitals for Crippled Children, failed to show any abnormality. The lengthening was obtained by plastic elongation at the musculotendinous junction, the wounds closed and long leg plaster casings applied. Because of the weakness of the quadriceps, the lengthening was made just sufficient to bring the feet to, and not above, the right angle.

The patient was discharged in plaster, and weight-bearing started with crutches two weeks after operation. This early mobilization was carried out because of our experience in seeing patients with dystrophy made bedridden after what normally would be but a temporary confinement. Four weeks after operation the plasters were bivalved and wounds found well healed. Exercises were started in the physiotherapy department.

Six weeks after operation daily injections of pilocarpine and adrenalin were started and given in the same manner as to his sister, Kathleen. Improvement was prompt and definite. Within two weeks there was increased muscular strength observed both objectively and subjectively. He still arose from the floor in the typical manner but with less difficulty. The quadriceps held against considerable resistance, and the pseudohypertrophic mass in the left thigh almost disappeared. The arms could be elevated fully above the head and held in horizontal abduction against considerable resistance. Before the completion of two courses of treatment he was able to stand from a sitting position without using his arms, and to get up from the floor without "climbing up the legs". He could bend forward, touch his toes, and resume an erect posture. He was able to run, although rather poorly. When last seen, on October 3, 1931, six weeks after the completion of his third course of injections, he was still showing improvement in functional ability. He could run, jump, and climb onto the examining table with ease. He now engages in all ordinary activities without difficulty, and only complains of some difficulty in going upstairs. This was the last thing to improve, and until recently he has found it necessary to reinforce the quadriceps by holding his knees.

These two cases in a brother and sister are presented as atypical familial dystrophy of unknown cause, without any recognized hereditary factor. They apparently represent clinically a transitional form between the Duchenne and the Leyden-Möebius types, pseudohypertrophic masses being present in one case and absent in the other. The occurrence of dystrophy in a female is also of interest, as it has been very rare in our experience; although various texts

state a ratio of three or four males to one female, this is the only case which we have seen in forty-two cases. The equinus deformity appeared earlier and has been more marked than in the ordinary cases, and the progressive nature has been less marked.

Of particular importance is the response to the treatment with pilocarpine-adrenalin, which was apparently of very marked benefit in the case of shorter duration. This is in accord with our previous experience[1]. One must, of course, still be very conservative in forming an opinion as to the permanence of this influence, since it has not yet been demonstrated for how long a period the improvement will be maintained. There seems little doubt, however, that in about fifty per cent. of cases, particularly in those seen early, there will be some definite benefit.

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CHANCE INFECTIONS FROM TYPHOID CARRIERS*

BY GAYLORD W. ANDERSON, M.D.,† AND CHARLES B. MACK, M.D.†

THE typhoid carrier who leaves a long trail of cases has been described so frequently and is so well known that an impression has been gained in many circles that all carriers are of this type. Consequently far less attention has been given to those carriers who in spite of their condition may, over a period of years, handle food for the consumption of others without causing typhoid infections. Many carriers may be found who had the disease twenty or more years prior to discovery and have remained in ignorance of their condition throughout these years. That they have not infected the members of their families may in large measure be due to the fact that repeated small doses of the infection have produced immunity rather than clinical cases of typhoid. Although this immunity cannot be proved by laboratory measures, its existence is strongly suggested by the fact that such carriers are usually discovered, not because of an infection in one of their constant and intimate associates but in some individual who has infrequently been in contact, direct or indirect, with the carrier. Yet even in such cases, it is often hard and even impossible to prove that these carriers may not have produced infections which, because of the indirectness of the contact, have not been traced to them.

Scant attention has been given in the literature to the carrier who has not caused infections in spite of several years' employment in the handling of food for a large controlled group of persons in whom the absence or presence of typhoid cases can be accurately determined[1]. It is our privilege to outline herewith the history of three such carriers who have recently come under our observation.

Mrs. M., aged 48, was brought to our attention in connection with the investigation of a typhoid outbreak in a girl's college. All of the eleven cases were among girls or employees who had been eating in the lunch room, in which Mrs. M. was employed as the cook. Her Widal showed partial agglutination (microscopic method) and two stool specimens were both positive for typhoid bacilli. She denied having had typhoid fever and when first questioned denied any protracted illness. On subsequent questioning, it was learned that her first husband had died twenty-two years prior of an illness considered to have been tuberculosis, though its total duration was less than one month. Immediately following his death she was ill in bed for about two months with malaise and weakness. No definite diagnosis of her condition had been made, though it had been variously pronounced as grippe, nervous breakdown and exhaustion. For the ten years following his death, she was employed by this same college, principally in a food-handling capacity. No outbreaks of typhoid occurred in the college at this time. She then remarried, but three years prior to the current outbreak she resumed her work, taking a place as cook in a small restaurant in a large city. It was impossible to determine possible typhoid infections caused in this way, though there was never any suspicion directed toward the restaurant. After working here for a little over a year, she obtained a position as cook in a lunch room of a large department store, staying there a year and a half. This lunch room was patronized by public and employees alike, several hundred meals being served each noon. The presence or absence of cases among the public eating here was impossible to determine, but during the year and a half no cases of typhoid occurred among the several hundred employees. Mrs. M. then entered the employ of the college, working for about a month in connection with the summer session and then assuming charge of the lunch room when the regular term opened the latter part of September. She continued to work there until she was removed on November 14. Several hundred girls ate there daily. The circumstances surrounding the cases proved almost beyond doubt that all of them were caused by a single article of food (presumably chicken croquettes) prepared by Mrs. M. on October 23. In other words, there was no evidence that she may have caused infections on more than a single day, and she almost certainly did not cause infections on any of the subsequent 22 days before discovery of her carrier condition.

Mrs. C., aged 58, had had typhoid fever twenty-one years ago. The discovery of her carrier condition resulted from an investigation of a case of typhoid fever in the person of her niece, a girl of twelve. Two weeks before the onset of her illness, she had spent a few days in a summer camp with her aunt and grandmother, both of whom had had

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typhoid. Stool specimens from Mrs. C. were positive for B. typhosus, from the grandmother repeatedly negative. No known cases of typhoid fever had occurred in Mrs. C.'s family following her illness 21 years ago. For several years she had been very active in women's work in her church, frequently helping in the preparation of church suppers and recently having had complete charge of the same. Her principal interest and pleasure lay in the preparation of these suppers. At no time had any cases of typhoid been connected with these suppers, nor had there been any outbreaks of typhoid in this community for many years. The few cases of typhoid that had occurred in this town (a suburban community of 16,000 population) had all been of a sporadic nature (only 16 cases during the preceding ten years) so that it is hard to believe that her participation in church suppers had ever caused unrecognized outbreaks.

Mrs. R., aged 65, had had typhoid 29 years prior to her discovery as a carrier. It was not possible to trace her contacts with any degree of certainty for more than the eight preceding years. During this interval she had been employed as cook successively in two related families. In neither had there been extensive entertaining though relatives had frequently been present for meals. Until the incident that led to the discovery of her carrier condition, no cases of typhoid had ever occurred among the members of either family, their relatives or dinner guests. Her discovery came as the result of investigation of the source of infection of a young man who shortly before his onset had visited for several days in the home where she was employed as cook and housekeeper. Her stools were positive for B. typhosus.

All three of the above carriers were persons noted for the cleanliness of their households and the neatness of their persons. The attention to cleanliness which characterized them was such as in each instance to be specially noted by those investigating the cases.

COMMENT

The histories of the three carriers presented above emphasize the fact, so often overlooked, that typhoid carriers can and at times do continue for years in a food handling occupation without necessarily causing infections. It is only when a number of variable factors all act simultaneously that infections may result. It is well, therefore, to consider briefly what may be these factors if we are to have a clear picture of the rôle of the carrier in producing infections.

In order that the carrier may transmit the infection to another through the vehicle of food, it is obviously necessary that the carrier implant viable typhoid organisms on or in the food, and that this food be consumed before the organisms have died. The first essential is, therefore, that the organisms shall be passed in viable form from the body. The intermittency with which carriers may shed viable organisms has been frequently pointed out, though there may still be some reasonable doubt as to certain of the variants upon which it is conditioned. The experimental work of Arnold[2, 3] has opened new fields for its investigation and presents a clear explanation of many of the determining factors. It lends special emphasis to the importance of a diarrhea on the part of the carrier as a factor favoring the discharge of viable organisms, and, therefore, the spread of the infection.

Granted then that the viable organisms are shed on the day in question, it is essential that these organisms be transferred to the hands of the carrier. Obviously the hands are not contaminated in every instance, yet only when they are so contaminated will the carrier be in a position to pass on the infection through food. Furthermore, in many instances when the hands are soiled the individual will wash and scrub them with sufficient thoroughness so that all viable typhoid organisms will be removed. That they are not always removed cannot, however, be considered as a reflection upon the habits of the carrier, due to the obvious difference between social cleanliness and bacteriologic sterility.

Another factor tending to minimize the possibility of spread of infection has been pointed out by Arnold[4] in the bactericidal power of the living skin. Although some doubt has been raised[5] as to the extent of this power, it is reasonable to assume that this, coupled with the natural drying which would take place, would materially reduce the possibility of the existence or at least the number of viable organisms on the hands at the time when food was handled. That the food may become infected it is necessary, therefore, that the organisms shall have been given off, transferred to the hands, incompletely removed by washing, and that the food be handled before the remaining organisms shall have died. The habits of many individuals to move the bowels but once a day and at a set hour may well act, therefore, as a protective factor in preventing many such infections.

A further factor is to be found in the food itself. If the food which is handled is to be thoroughly cooked before consumption, any organisms which may be introduced into it will, of course, be killed. A large portion of our foods are of this class so that in many instances the chain of events may be broken at this point. If, however, the food is such as will not be further cooked before consumption, or which though cooked will not be sufficiently heated in all portions so that all contaminating typhoid organisms will be killed[6], infection with this food as a vehicle may well take place. Many foods have at various times been incriminated as the vehicle for the spread of typhoid. They have apparently but one factor in common, namely moisture. It may well be inferred, therefore, that the typhoid organism demands for its tem-

porary survival in food naught but moisture and not too high a degree of acidity.

A final factor conditioning the development of a typhoid infection from food handled by a carrier is to be found in the individual consuming the food. Obviously the specific resistance of the individual must be at a level low enough to permit of the development of a clinically recognizable form of the disease as a result of the ingestion of the number of viable organisms consumed. As already mentioned, there is strong epidemiologic evidence to suggest that among the frequent and immediate contacts of a carrier a certain degree of immunity may have developed as a result of frequent small doses of the infection. In the home environment, therefore, the chain of events necessary for the transmission of typhoid may be frequently broken at the last link and a carrier go unnoticed for years. Under conditions as in Massachusetts where the incidence of typhoid has been at a low level for many years and artificial individual immunization is uncommon, the susceptibility of those not in frequent contact with carriers is relatively high. It is not surprising, therefore, to find that carriers are so frequently found through their infection of persons other than members of their immediate families.

These variants form a definite chain of events. If the chain is broken at any point, infection will obviously not occur. For the transmission of the disease from the carrier through the vehicle of food, all of these several factors must act in direct succession, and the omission or failure of a single one will serve as an effective barrier to all the others.

The possibility of a typhoid infection resulting from a single carrier on a single day is, therefore, directly dependent on the law of chance, necessitating the simultaneous occurrence of some six or seven variables. Keeping in mind the familiar rule that the possibility of the simultaneous occurrence of several variables equals the product of the chances of occurrence of the separate variables, it is readily apparent that typhoid infections from selected carriers may be extremely rare in their occurrence. The chance of occurrence of any one of the many variables outlined above would, of course, be a characteristic of the particular carrier, depending on the personal habits and routine of the individual. A slight variation in a single one of these will be greatly magnified in the product of chances and materially alter the probability of spread of infection. In the carrier whose characteristics are such, that as above, the chances of occurrence of a single variable are slight, few cases of typhoid may result. On the other hand, infections will be frequently spread by those carriers for whom the necessary variables are frequent in occurrence. Unfortunately it is these carriers that are most dramatic and more frequently described to the neglect of the carrier causing infections but rarely.

It is not to be inferred that we would minimize the importance of the typhoid carrier. On the contrary, it is our honest belief that in Massachusetts, at least, the carrier is today the most important single factor in the continued spread of typhoid, and that most of our residual typhoid could be traced back to carriers serving in a food-handling capacity (public or private) were it humanly possible to learn and investigate thoroughly all the "food contacts" that the patient had during the two or three weeks preceding the onset. That carriers are not more frequently found is due to the manifest impossibility of finding all these contacts.

CONCLUSIONS

1. Histories are presented of three proved typhoid carriers, who had been employed in a public or semi-public food-handling capacity for several years prior to their discovery without causing infections. In each instance the group of persons who had been consuming the food prepared by the carrier was such that the absence of cases could be definitely affirmed.

2. Several variable factors which are independent of each other, but all of which must act simultaneously, determine whether or not infections will be spread through the vehicle of food. If the chain of events is broken at any one of these several factors, infections will not occur.

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CASE RECORDS
of the
MASSACHUSETTS GENERAL HOSPITAL

ANTE-MORTEM AND POST-MORTEM RECORDS AS USED IN WEEKLY CLINICAL-PATHOLOGIC EXERCISES

EDITED BY RICHARD C. CABOT, M.D.
F. M. PAINTER, A.B., ASSISTANT EDITOR

CASE 18081

PALPITATION AND ACUTE MULTIPLE ARTHRITIS

MEDICAL DEPARTMENT

First admission. An Irish-American porter forty-nine years old entered for the first time a year and eight months before his second admission complaining of bleeding and prolapse from the anus, the bleeding of six years' duration. A rectal polyp (papillary adenoma) and hemorrhoids were removed.

He gave a past history of "typhoid pneumonia" at seventeen, sepsis of the right arm from an infected finger twenty-five years before admission, nocturia once or twice a night for years, intensely painful cramps in the feet with inability to walk for two weeks two years before admission, and moderate palpitation when nervous or excited.

Examination showed a greatly enlarged heart, the left border of dullness in the fifth space 13 centimeters from the midline, 5.5 centimeters outside the midclavicular line. The other measurements were not increased. There was a loud systolic murmur at the apex with a soft blowing early diastolic, the latter heard best down the left border of the sternum. There was a marked systolic murmur and a soft diastolic murmur at the aortic area. The pulse was bounding, tending towards the Corrigan type. The blood pressure was 175/70. The pupils were irregular, otherwise normal. The knee jerks and ankle jerks were normal. A Wassermann was strongly positive.

History of interval. For the next year and seven months he had no illnesses or symptoms. In May, five weeks before his second admission, he was ill in bed for two days with sore throat and malaise. Two weeks later he awoke one morning to find his right knee painful and swollen, with limitation of flexion, but with no redness or tenderness. As this subsided he had involvement of the left knee, then of the right elbow, wrist and hand, then of the right knee, the right arm, and the left knee again.

Second admission, June 10, a year and eight months after his previous discharge.

He now gave a history of gonorrhea thirty years before admission, treated by mouth. He urinated two or three times at night; he drank "much water" after supper. He was a periodic alcoholic.

Clinical examination showed a well-nourished man with his right arm propped up on a pillow, obviously painful. The nasal septum was deviated, with partial obstruction of the right nostril. There was very marked pyorrhea. The tongue showed coarse tremor. There was diffuse pulsation involving the vessels of the neck, the entire chest and the abdominal aorta, and a localized apical pulsation seen and felt 12.5 centimeters from midsternum, coinciding with the left border of dullness 4.5 centimeters outside the midclavicular line. The right border was 1.5 centimeters, the supracardiac dullness 7. The rate was rapid, 96. The sounds were forceful. There was an occasional dropped beat. The aortic second sound was accentuated. There was an aortic systolic murmur and a systolic at the base, also a soft early aortic diastolic in the third left interspace. No diastolic or presystolic was heard at the apex. There was no thrill. Capillary pulsation was present. There was questionable Corrigan pulse. The blood pressure on the left was 185/65. The lungs were clear in front. At the right apex in the back there was diminished respiration and increased breath sounds and voice sounds; no râles. The hands showed coarse tremor, slight clubbing of the fingers, slight edema. The right knee, elbow, wrist and metatarsal joints were swollen, tender, painful and red. Motion was limited, whether by pain or structurally was uncertain. The right ankle was swollen, not red, tender or limited in motion. The left knee was swollen, painful on motion, limited in flexion and showed a slight amount of fluid.

The amount of urine was 86 to 30 ounces, the specific gravity 1.012 to 1.032. There was a slight trace of sugar at two of five examinations, one to occasional white blood cells at two. Blood examination showed 10,800 to 6,500 white cells, hemoglobin 70 per cent, 4,400,000 red cells, differential count and smear normal. Hinton and Wassermann tests were each moderately positive once, strongly positive once. The blood sugar was 74 milligrams.

The temperature was 102.3° to 97°, the pulse 115 to 58; after June 12 both were normal. The respirations were normal throughout.

X-ray examination showed slight thickening of the lining membrane of the right antrum and marked alveolar retraction around the remaining lower teeth. The heart shadow was definitely enlarged, the enlargement entirely to the left. The curve of the left ventricle was prominent. The apex was blunted. The heart lay rather horizontal in the chest. There was also definite increase in the supracardiac shadow due in part at least to tortuosity of the aorta. In the oblique view the aorta was a little wide. The measure-

ments were right 4.5 centimeters, left 11.7, total transverse 17.2, length 17.5, base 9, great vessels 9, chest 28.5. Later examination confirmed the previous findings.

A South Medical consultant reported, "On the right side of the glans there are two round scars which are very suggestive." A throat consultant thought the sinuses did not require treatment. He advised tonsillectomy on the infected tonsils.

Under salicylates the joint symptoms disappeared. On June 24 the patient was discharged to the Outpatient Department.

Subsequent history. During the following July and August he made seven visits to the South Medical Outpatient Clinic, where he was given quinine bismuth iodide. On July 20 it was noted that the right hand was more swollen than it was the previous week. On August 17 the right arm and hand showed painless edema. In September he was transferred to an evening clinic at another hospital, where he continued to make weekly visits and receive treatment until May 12, a year and eight months later. No record was made of his heart condition. About eight months before his death his wife called Dr. Palmer to see the patient for a cold or some slight ailment. The heart was then doing well; in fact it never troubled him. He was able to move furniture, although he took his work comfortably. He continued to have periodic alcoholic bouts.

On June 7 his wife again called Dr. Palmer. She said that she had heard a slight cry and found the patient lying dead. The bedclothes were undisturbed. The posture of the body was a natural one, there being no evidence of struggle. The night before he had been perfectly well. There had been no immediately recent alcoholic excesses.

Clinical Discussion

BY RICHARD C. CABOT, M.D., GEORGE W. HOLMES, M.D., MAURICE FREMONT-SMITH, M.D., AND TRACY B. MALLORY, M.D.

NOTES ON THE HISTORY

DR. CABOT: I get very little in the way of suggestions from the past history.

We have first-rate evidence of aortic regurgitation as shown in the enlarged heart, the Corrigan pulse, the murmur and the big pulse pressure, four things which are backed up by the finding of the positive Wassermann, which suggests the commonest cause of aortic regurgitation at his age, syphilis. It may have nothing to do with the heart, but we naturally assume, until there is evidence to the contrary, that this is syphilitic aortitis with involvement of the aortic valve.

From the description of the joint lesions before his second admission it seems as if he had what is rather unusual at his age, acute articular rheumatism.

NOTES ON THE PHYSICAL EXAMINATION

I take it that in the examination of the nose they were looking particularly for what they did not find, a perforation, which might have been due to syphilis; that is, they tried to find confirmation of the suggestion given in the Wassermann.

"Marked pyorrhea." I think Dr. Fremont-Smith remarked last week that they might just as well leave those statements out, because they never give us information that has any relation to the diagnosis. I do not believe pyorrhea causes any of the diseases from which the people we see in these exercises die. I have long since ceased to pay any attention to pyorrhea except as a cause of damage to the teeth. Of course we have a general habit of looking at people's teeth nowadays as one of the sources of focal infection. No doubt they sometimes are, though much less often than is ordinarily supposed. When they are I think it is something at the root of the tooth and not these easily draining suppurations around the gums and teeth.

I take it the x-ray men did not think the findings on the teeth and sinuses were very important.

I do not know what to say about that tremor of the tongue and hands. There is nothing else in the case to suggest any particular cause for that.

The history says, "There was an aortic systolic murmur and a systolic at the base." I take it one of those means diastolic.

It seems as if the artery walls must have been very stiff so that they could not feel the pulse wave. It ought to have been Corrigan.

These lung signs are not in any way distinctive. Diminished respiration, increased breath sounds and voice sounds do not mean anything in particular to me. They can mean edema, pneumonia, hydrothorax, or simply relaxation above an enlarged liver.

There is nothing in the history to suggest why they should have tested the blood sugar.

One thing I have been trying to get from x-ray men for years is a diagnosis for or against syphilitic aortitis without aneurysm. I have not yet seen an x-ray man who would commit himself on the question, "Is or is not aortitis present?" unless there was aneurysm. I think you can see here the attempt to exclude aneurysm. I hope there was an attempt. After I have committed myself to a diagnosis we will look to see whether there is any report from the X-ray Department on syphilitic aortitis. So far I have never had any help from x-ray on this point, which certainly is a really important one.

Of course the important thing in the heart in the chest film is 17.2 centimeters, the total transverse measurement of the heart, as against 28.5 centimeters, the inside measurement of the chest. 17.2 is more than half of 28.5, so the heart is enlarged. Any heart more than half the total inside diameter of the chest cavity is enlarged. On the whole that is the best rule that we have. The base and great vessels are 9 centimeters wide. That should mean an increase. Whether that increase is due to an arteriosclerotic aorta or to syphilitic aortitis we have not yet any way to say.

The two round scars on the right side of the glans are suggestive of syphilis. The difficulty about these penile scars is that chancroid often gives scars which experts tell us are indistinguishable from those of chancre.

"A throat consultant thought the sinuses did not require treatment." That is what I surmised from the phrases used by the roentgenologist.

The patient was discharged I take it with a diagnosis of aortic regurgitation and presumably a diagnosis of syphilitic aortitis. We will come back to the question as to whether it was a rheumatic or a syphilitic process when I have come to the end.

The "South Medical Department" means the Syphilis Department. Patients are more likely to come back for treatment if the disease is not named on their card. His going there means that somebody here made that diagnosis and the patient was getting treatment for syphilis. The fact that no record of his heart condition was made is additional evidence that he was being treated for syphilis.

DIFFERENTIAL DIAGNOSIS

We do not seem to have any more facts at the end than we had when we went over them after the second admission. The only thing to discuss seriously is the etiology. On the facts given us we must say that aortic regurgitation is the main gross lesion. If we turn out wrong about that we shall still have to say our reasoning is correct from the given premises. You and I are not concerned with the premises. We can say aortic regurgitation on the basis of the enlarged heart, the aortic murmur heard not once only but again at subsequent visits, the Corrigan pulse and the big pulse pressure plus a definite but not marked evidence of limitation in cardiac power,—not marked because he carried on his work. Aside from that we have the acute joint symptoms. We have to remember that acute polyarticular symptoms of this kind can be due to syphilis. That is, they occur in syphilities and go off under antisyphilitic treatment, and there is no way that I know in which they can be differentiated in a syphilitic from what we call acute articular rheumatism. The fact that he had these does not prove he has any other disease but syphilis. It does not, on the contrary, prove he had it. There is one thing I have learned from these exercises that I cannot help bringing into my reasoning in this case. A diagnosis of syphilis hardly ever turns out right. In every one hundred diagnoses of syphilis that I have made in these exercises during the past twenty years about twenty-five have been right and seventy-five wrong, so far as Dr. Wright's, Dr. Mallory's and Dr. Wolbach's evidence goes, which is the evidence obtainable. Why that is so I do not know. For that reason I always make a diagnosis of syphilis with the greatest hesitation, especially when we have no more positive evidence than we have in this case,—a scar which is not necessarily syphilitic and a positive Wassermann. Aortic regurgitation can perfectly well be due to rheumatism or possibly to arteriosclerosis. Even a twice positive Wassermann is of course never convincing evidence.

Just at the right moment arrives Dr. Holmes, who is the man I have been looking for. Dr. Holmes, you and I have for a long time been taking council together over the diagnosis of syphilitic aortitis. I cannot decide from the clinical facts here whether the case is syphilitic aortitis.

MISS PAINTER: The films are missing, Dr. Holmes.

DR. CABOT: Let us see whether you would be inclined in that direction at all by the recorded description. Here is a man who has a twice positive Wassermann, scars on the penis which may be thought to be syphilitic, aortic regurgitation, the x-ray findings you are now reading, and that is essentially all.

DR. HOLMES: He has enlargement of the left ventricle apparently. The curve of the left ventricle is said to be prominent and the heart lies horizontally in the chest, findings which suggest enlargement of the left ventricle. That does not necessarily mean lues. There is also a definite increase in the supracardiac shadow, due in part at least to the tortuosity of the aorta. I should say they thought there was some increase in the actual diameter of the aorta but were not quite sure of it.

DR. CABOT: Does that oblique view of the aorta help us any?

DR. HOLMES: The oblique view does help in a fair percentage of the cases, because it is possible to see the aorta quite distinctly in this view. Possibly this case was one in which the view was not any too clear. We have found practically no cases of dilated aorta in which the supracardiac shadow is not increased. The increase may be due to arteriosclerosis, to hypertension or to luetic aortitis. I do not think we have evidence enough here to say which one of the three he had.

DR. CABOT: I did go as far as that.

DR. HOLMES: One ought to be able to tell

from the clinical history whether he had hypertension or not.

DR. CABOT: He certainly had a high systolic pressure. I am convinced that he had aortic regurgitation, whatever was the cause of the aortic regurgitation.

DR. HOLMES: If he had aortic regurgitation and a dilated aorta I should be inclined to think he had syphilitic aortitis and I should think there was evidence enough to say so.

DR. CABOT: Have we any more evidence at all? Of course I can see how an argument might be made, because he had acute polyarticular inflammation and because that by statistics is generally rheumatic and not syphilitic, though it may be syphilitic; that therefore he probably had previously had rheumatism on his heart valves and that he has the lesions due to that now. But I think I shall have to say I do not know. On the clinical evidence before me it does not seem to me one can say whether this is or is not syphilitic. The evidence for it is the evidence I have already given of the positive Wassermann, the heart lesion and the scars. I do not think the tremor of the tongue and the hands helps us at all. There are no lesions in the body showing any cutaneous syphilis. That is not necessary. There is no evidence of syphilis of the central nervous system. That is not necessary either. If anybody should say, "This man cannot have syphilitic aortitis," I should say, "No, we have not evidence enough to come down definitely and decide that it was or was not either one of those two things, syphilitic or rheumatic disease." Have we evidence enough to come down definitely as to the etiology of this case? I think if I had not had this long and disastrous experience with the diagnosis of syphilis I should be quite likely to be more in favor of that diagnosis. It certainly is not a rational process that makes me say, "Because I have failed so many times in making the diagnosis of syphilis, therefore I will not make it this time." That is not logical, because I have no idea why I have failed. But that is as far as I can go.

A STUDENT: What do you think caused the sudden death?

DR. CABOT: I think that perhaps has some bearing on the questions that I have so far had to leave open. If we take all the causes of sudden death we have to think first of cerebral hemorrhage. It may be even as sudden as this, though that is not a common form. In most cases of cerebral hemorrhage causing sudden death there is some warning, something to draw the attention of the bystanders. Death is not usually so quick as in this case. The fact that death was here so very quick is against what is otherwise the commonest of all causes of sudden death, cerebral hemorrhage.

The next commonest cause of sudden death is pulmonary embolism. We do not ordinarily make a diagnosis of pulmonary embolism unless we have some idea where the embolus can come from. If he had had an operation at any time within two or three weeks one would say that was a possible cause. If he had varicose veins, if he had any lesion in the body from which we could easily imagine an embolus could be detached we should be justified in saying embolism. The only place I can think of is the inside of the heart itself. I think the heart has been failing for a long time. In such cases intracardiac clots often form and cause pulmonary embolism. He has however had good compensation. He has not the kind of heart in which intracardiac thrombi ought to form. There is no suggestion of a place from which he could have got a pulmonary embolism.

What have we left? We have the blocking of a coronary artery with cardiac infarction as the next commonest cause of sudden death. The coronaries are blocked sometimes in their course by thrombosis or by fibrous tissue and sometimes at their mouths by syphilitic aortitis. The fact that he has, then, a kind of death which might go with syphilitic aortitis through the blocking of an artery at its mouth is one of the things which perhaps ought to sway us a little more towards that diagnosis. In view of this it seems to be a little more probable than the other side.

Another possible cause of sudden death is the bursting of an aneurysm, which of course is one of the things any man suspected of syphilis might have. Bursting of an aneurysm does not often give such a sudden death as this. There usually are pain and other things that call attention of bystanders to the fact that the patient is sick. I do not believe that this was a ruptured aneurysm just because the death was so sudden.

Because I cannot think of any other plausible cause of sudden death that would be due to a rheumatic type of aortic regurgitation it seems to me on the whole I must do that very dangerous thing, make a diagnosis of syphilitic aortitis. In view of what has just been brought out on this question as to the kind of death it seems to me that that is more probable than anything else.

A STUDENT: How do you explain the edema of his right arm?

DR. CABOT: There is not much said about it, is there? We do not know how it was on June 7. It was present a whole year before he died. In view of that it seems to me we shall have to say no, we cannot explain the edema of the right arm. I think it was probably due to the same cause that produced his arthritis. Sometimes we do have edema of the whole of the hand or the whole of the forearm from the same organism that causes the arthritis. I cannot make anything else of it. I should like to connect it more distinctly with his heart, but I cannot.

DR. FREMONT-SMITH: I should like to bring

up one point. Isn't it taught that in a young person with pancarditis we have also an aortitis and often a dilated aorta?

DR. HOLMES: Yes, I should say so.

DR. MALLORY: Most of the time rheumatic aortitis is a microscopic rather than a macroscopic matter. I have not been impressed with gross dilatation in the cases I have seen, though it is reported to occur.

DR. CABOT: It seems to me that the important point is that this man was not sick until he was past forty, so far as we know. Of course rheumatic infection can begin after forty, but for syphilis that is the most usual time.

A STUDENT: Aren't there two things that might suggest aneurysm on the right? First edema of the right arm. The record specifies that at the second admission the blood pressure was taken on the left arm. Then again there may be some pressure signs at the apex of the right lung.

DR. CABOT: I suppose his right arm was too sore at that time for blood pressure measurement. As for those signs in the lung, I cannot make anything of them. It is perfectly true that we might get pressure signs from aneurysm, but if the aneurysm is big enough to exert pressure on the lung it certainly would be visible by x-ray. I think we can exclude aneurysm definitely. I shall have to be very vague about the lung signs. My best guess is that there is nothing wrong with the lung at all.

A STUDENT: In syphilitic joints is the involvement as migratory as this?

DR. CABOT: Yes, I think so.

A STUDENT: Would syphilitic arthritis respond to salicylates?

DR. CABOT: Yes. No arthritis in my opinion responds to salicylates except that they alleviate pain. I think salicylate is a good drug for any pain. So I should not say that has any particular diagnostic bearing. I am not excluding the possibility of rheumatic joints and a rheumatic heart. It could be that; but the balance seems to incline to the other side.

One other possibility is bacterial endocarditis on his aortic valve, implanted on an old rheumatic process. If he had that you can see how an embolic fragment might block a coronary and cause death. In the absence of positive blood culture, however, it is very risky to make a diagnosis of a disease as serious as bacterial endocarditis, but I think we can exclude it.

A STUDENT: He died about one year after the x-ray was taken. Could aneurysm develop in that time?

DR. CABOT: That is a rather good point. He was seen only a month before death by the same man who had been seeing him right along, Dr. Palmer. I presume he did not have a portable x-ray machine with him, but I think the chances are a good deal against aneurysm. The time relation there is important. I am against aneurysm, though I think you have a fighting chance there.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Luetic heart disease.

DR. RICHARD C. CABOT'S DIAGNOSES

Syphilitic aortitis.
Hypertrophy and dilatation of the heart.

ANATOMIC DIAGNOSES

Arteriosclerosis.
Hypertensive heart disease.
Syphilis.
Syphilitic aortitis with aortic regurgitation.
Partial stenosis of the orifices of the coronary arteries.
Possibly rheumatic endocarditis of the mitral valve.
Possibly rheumatic myocarditis.
Hypertrophy of the heart.

PATHOLOGIC DISCUSSION

DR. TRACY B. MALLORY: Our autopsy in this case was limited to the heart and the aorta. The heart weighed 750 grams,—marked enlargement. We found lesions on two valves, the aortic and the mitral. The lesions on the aortic valve however consist of definite separation of the cusps which I feel confident we can say was certainly syphilitic. The lesions all look very slight and old. I think he probably had had rheumatic endocarditis sometime years before. There was apparently no fresh rheumatic lesion from this last attack of arthritis, supposing it was rheumatic. The mouths of both coronary arteries were distinctly narrowed. The mouth of the right coronary was less than one third normal size, that of the left about half. Neither of the coronary arteries was completely occluded, and beyond their mouths they were perfectly normal in size and diameter, as is so often the case in these luetic lesions, which are sharply limited to the mouth of the vessel. A considerable number of these cases do have sudden death even when the coronary mouth is not entirely occluded. In looking back I think that that unquestionably was one of the important diagnostic factors in the case, for sudden death is much commoner in luetic than in rheumatic involvement of the aortic valve. The aorta showed rather diffuse syphilitic aortitis, but no aneurysm.

DR. CABOT: How do you account for sudden death in cases where there is no actual closure of the coronaries?

DR. MALLORY: I think it is rather hard to account for it. I should be inclined to counter with another question. How do people with complete closure of the coronaries live as long as they obviously do? Is it a matter of compensatory circulation which proves adequate for a certain

length of time and suddenly fails for no demonstrable reason?

DR. CABOT: Was there no infarction here?

DR. MALLORY: Not in the least.

DR. CABOT: Was there nothing in the lungs?

DR. MALLORY: We were not allowed to examine them. We were limited strictly to the heart and the aorta.

CASE 18082

RAPIDLY DEVELOPING ASCITES AND CACHEXIA IN AN ILLNESS OF SHORT DURATION

MEDICAL DEPARTMENT

DR. ASHTON GRAYBIEL*: This is the case of a colored laborer aged forty-two who entered complaining of a swollen abdomen.

First admission. He had had a previous admission fourteen years earlier. At that time he entered complaining of weakness, chills and fever. He gave a history of repeatedly becoming jaundiced after drinking too much alcohol and of having had a chancre. A Wassermann was moderately positive on two occasions, negative once. Dr. C. Morton Smith thought the patient's illness was not due to lues. X-ray examination of the lungs was negative; that of the heart showed slight enlargement; the bones showed questionable luetic involvement. The patient quickly responded to symptomatic treatment.

History of interval. After discharge the patient was entirely well until one month before his readmission. At that time he had to stop work because of epigastric pain, especially when he bent over. Three weeks before readmission he noted gradually increasing abdominal distention, and had pain and a feeling of tightness in his abdomen. At times he felt "water" splashing in his abdomen. His bowels were constipated. He had frequency of urination with burning. For the week before readmission his urine was dark colored.

Second admission, fourteen years after his previous discharge.

Examination showed a fairly well developed but poorly nourished colored man in evident distress, complaining of abdominal pain and distention. The pulse rate, temperature and respirations were normal. The pupils were slightly irregular but reacted normally to light and accommodation. The heart was pushed up by the diaphragm. The apex impulse was in the fourth space 10 centimeters to the left of the midsternal line. There was a slight systolic murmur at the base. The diaphragm was high on both sides. The lungs were resonant and clear. The abdomen was markedly distended, with noticeable engorgement of the superficial veins along the right costal margin. There was definite fluid wave and shifting dullness. In the epigastric region a mass could be palpated by ballottement, probably the liver. The knee jerks and ankle jerks were absent. There was no plantar reflex. There were old scars on both legs.

The urine and stool examinations were not remarkable. The white blood cell count at entrance was 12,500. Later it increased to 18,000. The hemoglobin was 80 per cent, the red count 4,960,000. A smear was normal. A liver function test showed a dye retention of 35 per cent. Two Hinton tests here were negative. One at the State laboratory was positive.

Symptomatic treatment and diuretics were of little avail. The patient ran a rapid downhill course. It became necessary to give all fluids intravenously. The rapidly accumulating ascitic fluid made frequent abdominal paracenteses necessary. The fluid obtained on puncture was of low gravity (1.012), yellow, and contained a small number of red blood cells and lymphocytes. Hinton and Wassermann tests on the fluid were negative. Culture showed no growth, and guinea pig inoculation was negative for tuberculosis.

On the eighth day the patient became semicomatose and on the tenth day developed a fever (102° rectal) and a rise of pulse rate (120) and respirations (35). He gradually went into coma and died on the twelfth day.

CLINICAL DISCUSSION

DR. WYMAN RICHARDSON: The only striking thing to me about this case was that whereas it looked like the terminal stage of cirrhosis the course was very rapidly downhill, much more so than would have been expected from the patient's condition when he first came in. I did not have any idea about the diagnosis other than that it was a rapidly progressive lesion of the liver.

DR. CHESTER M. JONES: Was he jaundiced?

DR. RICHARDSON: He was deeply pigmented. It was difficult to determine clinically whether there was jaundice, because he was a mulatto. I do not remember whether or not we did any test for that.

DR. GRAYBIEL: One van den Bergh gave a direct red reaction, approximately 1.0 milligram per 100 cubic centimeters, and another a direct red, 2.8 milligrams. The icteric index was 8 to 10.

DR. JAMES HOWARD MEANS: Is a very rapid downhill course more in favor of syphilitic cirrhosis than of portal cirrhosis?*

DR. TRACY B. MALLORY: I should say it is against it. Judging from the records in our laboratory the majority of cases of syphilis of

*Recently senior interne on the East Medical service.

*A case in point is to be found in Guy's Hospital Reports, October 1931, page 485.

the liver have no symptoms referable to the condition. In 6,000 autopsies we have had only 28 cases of fairly certain luetic involvement in the liver. Eight of these were infants with congenital lues. Of the remaining 20 cases, though syphilis with its cardiovascular lesions was the primary cause of death in four, no symptoms could be referred to the liver in these or in 11 other cases where the condition was a purely incidental finding at autopsy. The data available are insufficient in two other cases, so we are left with only three cases in which the liver lesion was certainly the cause of the symptoms or of death.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Cirrhosis of the liver.

ANATOMIC DIAGNOSES

Cirrhosis of the liver.
Hepatoma.
Inflammatory swelling of the mucosa of the stomach.

PATHOLOGIC DISCUSSION

DR. MALLORY: This case was to all intents and purposes undiagnosable except on the autopsy table, and incidentally we failed to make the diagnosis there. It was not until the sections came through that we found it.

He had a very obvious marked cirrhosis, but a very big liver, so big in fact that we were suspicious of something more than cirrhosis. Although the exterior did not suggest tumor, in the central portions we found large infiltrating tumor masses. We supposed that they represented metastatic tumor, and when we found a peculiar area of rather marked thickening and induration in the stomach we thought he had cancer of the stomach with metastases in the liver and elsewhere. When the microscopic sections came through we found no cancer of the stomach. There was only an acute inflammatory process with thrombosis of many of the smaller blood vessels in the stomach wall. The histologic appearance of the tumor nodules is consistent with primary cancer of the liver, which of course under ordinary conditions occurs only in people with preceding cirrhosis. This man probably had had cirrhosis since his first admission fourteen years before his death. He was just the right person to develop primary cancer of the liver. That would account for the rapid downhill course.

This makes the sixth case of primary liver cell carcinoma we have had in five years. I have looked back over the older cases, but I could find only two cases that I was convinced were primary hepatoma.

DR. WILLIAM BRADFORD ROBBINS: Have you had many cases of syphilitic cirrhosis in the past year? Aren't they very rare?

DR. MALLORY: Yes. We have had very few recently.

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CHANCE INFECTIONS FROM TYPHOID CARRIERS

EVER since the early work on the importance of typhoid carriers, and the rather romantic though unlovely story of "Typhoid Mary", epidemiologists have added an interesting narrative touch to medical literature with reports of epidemics caused by such carriers. The circumstances surrounding these outbreaks have had a dramatic element which appealed to the imagination and served to whet the appetite for mystery and its solution.

The discovery of a carrier has often served as a point of departure for further investigations to determine to what extent this individual may have caused infections the sources of which have previously gone undetermined. So frequently have such been found and so interesting have been the trails, that many have pictured the carrier as always leaving behind a devastating wake of disease. So firmly has this impression been established that the epidemiologist has, in his investigations, frequently found the feeling, even among the medical profession, that a certain individual could not possibly be a carrier simply because no typhoid has previously been traced to him.

Considerable interest may, therefore, be aroused by an article in the current number of the *Journal** describing proved carriers who, though handling food for a period of years, have apparently not caused infections. From the point of view of public health such individuals are just as important as the carrier who leaves a more dramatic trail. So long as their condition continues and they persist in the handling of food for the consumption of others, there is the constant threat of explosive and serious outbreaks of the disease, all the more devastating in a community like Massachusetts, which, because of continued low incidence of typhoid, has developed a high degree of susceptibility.

*Page 398.

INCREASE IN CHILD GUIDANCE WORK

THE National Committee for Mental Hygiene, which has recently finished a nation-wide inventory of existing facilities for the study and management of mental disorders and behavior and personality problems, finds an increasing tendency to seek medical advice and treatment for these conditions when the earliest symptoms appear.

Of especial significance is the marked growth in the number of mental hygiene and child guidance clinics established in various communities in the United States during the past ten years. In 1920 such clinics were comparatively rare; today there are some 674 in 34 states, most of these having come into existence since 1922, when The National Committee for Mental Hygiene and The Commonwealth Fund joined forces in the development of organized child guidance work. During the past year, to show the scope of this work, more than 50,000 children with various types of behavior disorders and mental problems were examined and treated in these clinics, and some 36,000 older persons appeared at the clinics for maladjusted adults for treatment of their own mental problems. This is equal to about half the number of patients admitted to mental hospitals in the United States each year.

A directory of clinics compiled by The Commonwealth Fund is about to be published and shows the states having the largest number to be New York, Pennsylvania, Massachusetts, New Jersey, Michigan, Colorado and Ohio. Cities, also, have been rated on their child guidance work, the assumption being that for every 200,000 of population there should be at least one clinic having the combined full-time services of a psychiatrist, psychologist and two psychiatric social workers. On this basis, Worcester, Mass., has the largest pro rata child

guidance service among the cities of the United States, being credited with 130 per cent. Next in order are Hartford, Conn., Grand Rapids, Mich., Providence, R. I., Richmond, Va., Flint, Mich., Newark, N. J., Boston, Mass., and Washington, D. C.

THIS WEEK'S ISSUE

CONTAINS articles by the following named authors:

MILLER, RICHARD H. A.B., M.D. Harvard University Medical School 1910. F.A.C.S. Assistant Professor of Surgery, Harvard Medical School. Associate Surgeon, Massachusetts General Hospital. His subject is "Umbilical Hernia." Page 389. Address: 264 Beacon Street, Boston, Mass.

OBER, FRANK R. M.D. Tufts College Medical School 1905. Clinical Professor of Orthopedic Surgery, Harvard University Medical School. Assistant Dean in Charge of Courses for Graduates, Harvard University Medical School. Orthopedic Surgeon-in-Chief, Boston Children's Hospital. Surgeon-in-Chief, New England Peabody Home for Crippled Children, Newton Center, Mass. His subject is "A Plan for the Management of Arthritis in Large Communities." Page 392. Address: 234 Marlboro Street, Boston, Mass.

FRENCH, RALPH W. A.B., M.D. Harvard University Medical School 1910. F.A.C.S. Surgeon on the Staff of the Truesdale Hospital, Fall River, Massachusetts. His subject is "End-Results in a Series of Sixteen Cases of Fibrosarcoma." Page 393. Address: 151 Rock Street, Fall River, Mass.

HOUGH, GARRY DEN. B.S., M.D. Harvard University Medical School 1921. F.A.C.S. Associate Orthopedic Surgeon, Shriners' Hospital for Crippled Children, Springfield, Mass. Orthopedic Surgeon, Wesson Memorial Hospital, Springfield, Mass. His subject is "Two Cases of Atypical Familial Dystrophy." Page 396. Address: 146 Chestnut Street, Springfield, Mass.

ANDERSON, GAYLORD W. A.B., M.D. Harvard University Medical School 1928. Director, Division of Communicable Diseases, Massachusetts Department of Public Health. Address: 546 State House, Boston, Mass. Associated with him is:

MACK, CHARLES B. D.P.H., M.D. Jefferson Medical College of Philadelphia 1910. State District Health Officer, Massachusetts Department of Public Health. Address: 546 State House, Boston, Mass. Their subject is "Chance Infections From Typhoid Carriers." Page 398.

THE BOSTON MEDICAL LIBRARY

JOHN JEFFRIES

1744-1819

THE name of Jeffries was a familiar one to Bostonians of the past generation and apparently deservedly so, both in their own right and in consideration of the character of the stock from which they were derived. It is from the contemplation of the lives of men of colonial times that we often learn a great deal that is of significance, not wholly concerned with the personal and professional accomplishments of the individuals, but more particularly relating to the things about which men thought and over which they became agitated. On the fifth of February, 1744, the subject of this sketch was born in Boston. David Jeffries, his father, had been treasurer of the town for more than thirty years and was highly respected. His mother was a Portsmouth woman. He apparently was orphaned at an early age and was adopted by an uncle who procured a tutor for him, by whom he was prepared to enter Harvard College. He was graduated from Cambridge in 1763, at the age of nineteen. He immediately decided upon medicine for a career and placed himself under the tutelage of Dr. Lloyd, who was much in demand as a preceptor by those who were desirous of becoming physicians. It was at this time that one of the malignant epidemics of smallpox swept over the city. He was sent by Dr. Lloyd to attend smallpox patients at the hospital erected on Castle Island for the isolation of cases of that disease and it was while there that he made some observations that tended to alter, not only his view but the views of others, as to the desirability of instituting what was called at the time, the "antiphlogistic" treatment. Four smallpox patients in the Hospital at Castle Island, in their delirium, escaped from the wards and jumped into the channel. They were rescued and brought back; all of them recovering, whereas many others apparently no worse off succumbed to the disease. From this observation Jeffries inferred that a cold bath was good treatment for the disease. Certain European physicians had already reached this conclusion and Jeffries' success in the treatment of other cases of smallpox, upon the antiphlogistic principle, served to corroborate these European views among practitioners in this country. At about this time Harvard conferred upon him the Master of Arts degree and he began his practice in Boston, soon acquiring an enviable reputation as a skillful physician. Not satisfied with his professional experience he decided to go abroad for further study. In England he spent some time studying chemistry and the practice of physic under the tutelage of

William Saunders and in obstetrics under Colin Mackenzie. For a year he was a dresser at Guy's Hospital, under Messrs. Way, Smith and Martin. On June 1, 1769, he presented and defended a Latin thesis and received a medical degree from the University of Aberdeen, being the first American to achieve that honor. He returned to Boston that same year and resumed his practice. He was appointed as an Assistant Surgeon to the British fleet on the North American station which connection he kept up so long as Captain Symonds remained on the station. At the time of the American Revolution his services were commandeered by General Howe and after the Battle of Bunker Hill he rendered valuable assistance to the wounded of both sides. It was he who identified General Warren to General Howe when he was picked up on the battlefield. When the British garrison evacuated Boston, Jeffries accompanied their general to Nova Scotia where he was appointed as Surgeon-General to the English forces in that Province. Two other promotions followed. He vaccinated some 1500 of the troops in Halifax without a single untoward result, for which he was commended by his commanding officer just as he was about to sail for England, on leave. So conspicuous had been his service to the British troops in the Colonies and the Provinces that he was highly recommended to the government, and the Secretary of War ordered that he be examined for promotion to the position of Surgeon-Major to the American forces. This examination was conducted by Mr. John Hunter who certified him as eminently qualified. Until he received his commission and sailed for America again, he spent considerable time with Mr. Hunter in his Surgery and in the dissecting room. In February, 1780, he reached Savannah and joined Sir Henry Clinton's force, where he was detained a long time. The latter part of 1780 found him back again in England, when he received a very flattering offer from Dr. Baillie, who was then on the road to become one of the foremost physicians of England. He was offered an opportunity to accompany Lord McCartney and a medical staff, to India. About this time he became afflicted with nostalgia and declined the offer. During this visit to England he made the acquaintance of a family of note, to a member of which he had been able to render a conspicuous professional service in America. For this they were duly grateful. Another member of the family, under the care of an English physician, was being so unskillfully handled that Jeffries felt he ought to interfere. A change in treatment effected a prompt recovery, the dismissal of the local doctor, and a note from the head of the family stating he wished him to consider himself as physician to the family and asking him to accept a carriage that was in waiting, as they could not employ a doctor who walked to his patients. He declined the honor of ministering to such a household as he preferred to stand upon his own feet and make his own way. As a consequence of other services that he rendered to members of the English army, stationed in America during the Revolutionary War, he made many valuable friends in England, who introduced him into the best circles of London practice. By some of these friends he was urged to follow the custom prevalent in London at the time and devote himself to a particular line of practice. He chose obstetrics and the diseases of children but subsequently broadened the scope of his work to include surgery and medicine. He was interested in science and managed to devote some of his time to research, along the lines of aërostatics, atmospheric temperatures, etc. This led to his making two flights in balloons, one from Grosvenor Square in London down into Kent and the second across the Channel from Dover into Artois, France. This latter flight was on January 7, 1785 and marks the first crossing of the English Channel via the air route. So much attention did this attract that he was at once brought into close relation with many influential scientific people through whose patronage his practice was greatly increased. In 1789 the necessity for his presence in Boston with reference to a bequest that had been made for his benefit, compelled him to cross the water again and this time he listened to the entreaty of friends and the lure of his native soil to make Boston his permanent home. It might have been expected that one who had deserted his country at the time she was struggling for independence, to serve in the medical department of the British army, would have created antagonism, but such does not appear to have been the case, for he was allowed to settle in Boston and soon acquired a good practice among the best people of the town. It is thought that he gave the first public lecture on anatomy that was given in Boston. He was also interested in physiologic experimentation which was based upon inductive reasoning. His studies upon digestion converted him to the belief that to the bowel we must go for an explanation of much that happens in the human economy. He was averse to holding public positions and refused several times the importunity of his friends to allow them to put his name up for appointment to a professorship and he was also disinclined to publicity through the press. For more than forty years he kept a daily meteorologic record three times per day. It was said of him that he never refused a professional call. He had a large following of medical students who sought to work under him as apprentices. After fifty-three years of practice he succumbed to what would doubtless be regarded today as a strangulated hernia, at the age of seventy-six.

It was during his flight across the Channel that he received the strain which caused the hernia.

Boston's physicians have had many grounds for distinction but to Jeffries seems to belong the palm for pioneering in aeronautics.

MASSACHUSETTS LEGISLATIVE NOTES

SENATE 264—An Act further extending the Time during which Certain Persons residing in Worcester County who are suffering from Pulmonary Tuberculosis may receive Temporary Care and Treatment at Certain Institutions.

HOUSE 1174—Resolve providing for an Investigation relative to the Advisability of Providing for the Care, Maintenance and Instruction at County Training Schools of certain Indigent and Physically Handicapped Children.

HOUSE 1177—An Act making Further Regulations relative to Bovine Animals which have reacted to a Tuberculin Test.

MISCELLANY

A RADIO MESSAGE PREPARED AND SPONSORED BY THE COMMITTEE ON PUBLIC EDUCATION OF THE MASSACHUSETTS MEDICAL SOCIETY FOR THE DEPARTMENT OF PUBLIC HEALTH

Rabies or Hydrophobia*

Rabies, also known as hydrophobia, is a very important and much dreaded disease, not because it is so frequent among human beings, but because when and if it develops, it is invariably fatal. That it is not more common among human beings is due solely to the fact that modern medicine possesses a wonderfully effective means for its prevention. Otherwise, cases would occur so frequently and would be so terrible that the health officer who would control the disease would find enthusiastic support from every thinking citizen in the community. It is only because the disease is usually so effectively prevented in human beings that all efforts to eradicate it completely are but signals for outbursts of abuse and sentimentality directed against honest conscientious endeavor.

The explanation of why sentiment and emotions are so often allowed precedence over reason lies in the fact that rabies is spread not by man but by dogs. The dog has rightly been characterized as man's best friend, and he is so long as he is healthy. But once the dog is rabid, this best of friends unwittingly turns into man's worst enemy. No dog owner who really cares for his pet is anxious to see it suffer a rabies death. The careful owner will therefore welcome all attempts to protect the animal just as he welcomes all measures to protect the health of his children.

Rabies is caused by a definite germ which is present in the saliva of a rabid animal, usually a dog. When and if this dog bites another dog, it injects the saliva and the germs into the body and in this way passes the disease along to another dog. If in the course of its wanderings, the rabid dog bites a person, it similarly may inject the saliva and the germ into the human body. Of course, if it bites through clothing, a great part of the saliva may be wiped off from the teeth so that a much smaller amount finds its way into the body. It is for this reason that bites through clothing are usually less serious than bites on exposed parts of the body. On the other hand, if the saliva and the germs it contains come in contact with cuts, scratches or other breaks in the skin, the germs may just as surely find their way into the body. Cases of rabies have thus occurred from the handling of rabid dogs, even though no bite has been inflicted.

After the germs get into the body, they spread up toward the brain. Some types of germs may be picked up by the blood and thus quickly carried to all parts of the body. The germs of rabies, however, act more slowly. Rather than entering the blood stream, they spread slowly along the nerve fibers until ultimately they reach the brain. It is for this reason that so long a time must elapse before any symptoms of the disease appear. There are no signs or symptoms of the disease until the germs reach the brain, but as soon as they do, it is soon fatal. This peculiarity of the germs to grow along the nerves explains also why the disease develops quickly in some people but slowly in others. Some of the nerves, such as those around the head and neck, may be very short so that the distance the germs must travel to reach the brain is short. Other nerves, as those of the arms and legs, are long and it will naturally take longer for germs introduced in this part of the body to reach the brain.

If a person has been bitten by a rabid dog, he should have prompt medical care. This means treatment of the wound and injections to prevent rabies. Treatment of the wound means cauterization to destroy as many of the rabies germs as possible. Mercurochrome, iodine, and other household disinfectants do not cauterize; stronger chemicals are needed. After this come the injections. This method, known as the Pasteur treatment, is the principal reason why rabies is today so rare a disease because protection is thereby secured. Before they were known, deaths from rabies were all too frequent, and a bite by a rabid dog meant a long period of hideous waiting full of fears and anxiety lest the victim might develop the fatal disease. Today, thanks to the injections, deaths from rabies among persons properly and promptly treated are almost unknown. These injections can be given you by your family physician. They are your surest protection. Usually about six weeks elapse after a bite

*Broadcast: January 7, 1932, Station WBZA—4:50 P. M.

before rabies begins. There is, therefore, ample time to obtain protection from the injections if they are begun promptly. Face bites being more serious, greater haste is, of course, necessary.

We have assumed so far that the dog is rabid. It would certainly be wrong to give the impression that whenever a dog bites it means that it is rabid. In fact, it usually isn't. It may have been an accident; the dog may have been annoyed or even be vicious, but not rabid. On the other hand, whenever a dog has bitten a person, it should be carefully watched to determine whether or not it is in the early stages of rabies. If it is, a diagnosis can be made and treatment of the person started; if not, treatment is unnecessary. Too many people are inclined to permit their anger to overweigh their judgment and to kill a dog simply because it has bitten someone. In this way many valuable dogs may be needlessly killed merely to satisfy the pique of the victim. Furthermore, the person who is bitten may be left in a serious quandary as to whether treatment is needed. It is true that laboratory examination of the dog's brain may show rabies, but in many instances, if the dog is killed immediately and before symptoms appear, it may be too early in the disease for the changes by which it is recognized under the microscope to have appeared. For your sake and for the sake of the dog, never kill a dog simply because it has just bitten somebody. To do so is worse than useless.

In certain cases the dog that did the biting is a stray animal and immediately disappears. Here there is only one safe course to follow, namely, to take treatment. This is probably unnecessary in most instances for the chances are that the dog is not rabid. On the other hand, no one can tell, and if it happened to have been rabid, it will be too late to start treatment after symptoms of the disease appear. There are, therefore, two things to remember in all cases of dog bites; first to keep the dog under observation to make certain whether or not it is rabid, and second to take treatment promptly if the dog is rabid or if it cannot be located. If these simple measures were followed in all cases, human deaths from rabies would entirely cease.

We would then be faced solely with the problem of the prevention of the disease in dogs. Annual vaccination of dogs against rabies has been tried and yielded surprisingly good results. Though not perfect, it can be strongly recommended to all dog owners who are anxious to afford their pets the utmost protection, not solely for human beings but also for the safety of the animal itself. If the dog is worth having, it is worth protecting.

A final measure of protection lies in the restraint of all dogs over a large area for a period of time. As the disease usually takes about two months to develop in a dog after it has been bitten, periods of several months' restraint must be observed if anything is to be accomplished. For this to be effective, the hearty coöperation of all concerned is necessary. If a few are unwilling to help, they can defeat whatever good might come from their neighbor's efforts. Other countries and other states have effectively controlled rabies in this simple way. That it has not been effective in this state has been due solely to the unwillingness of a few to help out. Until such time, we must expect to have a rabies problem and to put our sole reliance on the effectiveness of the protective treatment of persons who have been bitten by rabid dogs.

CHILDREN'S BUREAU EXPLAINS PROCEDURE IN ALLOTTING FUNDS

The Children's Bureau itself did not approve or disapprove State plans for using Federal funds under the former maternity and infancy statute, but acted upon recommendations of the Federal Board of Maternity and Infancy Hygiene which did stamp approval, Katharine F. Lenroot, acting chief of the Bureau, announced orally February 11.

Miss Lenroot explained that confusion and misunderstanding have arisen in reference to the operation of that Act, generally known as the Sheppard-Towner Act, which was frequently cited in the recent hearing on the welfare and maternity bill (S. 572) before the Senate Committee on Commerce.

PROVISIONS OF STATUTE

Also, Miss Lenroot pointed out that work under that Act was confined to mothers, infants, and children of preschool age. She made the following additional explanation:

The Federal Board of Maternity and Infancy Hygiene consisted of the Surgeon-General, the Commissioner of Education, and the Chief of the Children's Bureau. State plans varied as circumstances differed, and plans were worked out to meet local needs within the meaning of the statute. There was no difference of opinion in the Board by the inclusion of preschool children within State plans of carrying out the act.

The whole intent of the act was self-initiation on the part of the State. The general work was educational, and was centered primarily on mothers and babies living in areas of small population where hospital and other health facilities were lacking or meagre. Information was given to adolescents and prospective mothers through health conferences, visits to homes by nurses, and group instruction.

Infant care was explained along with prenatal instruction. Graduate courses in pediatrics and obstetrics for physicians were instituted and lectures, motion pictures, slides, charts and exhibits were employed in the educational process.

Where mortality rates were high from certain communicable diseases, information on immunization against diphtheria and smallpox, for example, was circulated as a protection to infants and preschool children.—*U. S. Daily.*

COMPARISON OF DISEASE INCIDENCE IN CONNECTICUT WITH 1931 AND SEVEN YEAR AVERAGE

MONTH ENDING FEBRUARY 6, 1932

	1932					1931			
Diseases	Week ending Jan. 16	Week ending Jan. 23	Week ending Jan. 30	Week ending Feb. 6	Average cases reported for week corresponding to Feb. 6 for past seven years	Week ending Jan. 17	Week ending Jan. 24	Week ending Jan. 31	Week ending Feb. 7
Anthrax	—	—	—	—	—	—	—	1	—
Cerebrospinal Men.	2	1	1	1	1	1	4	—	1
Chicken Pox	127	118	186	109	109	135	113	88	82
Conjunctivitis Inf.	2	—	—	—	4	1	—	2	8
Diphtheria	7	9	6	3	33	10	15	11	10
Dysentery Bacillary	—	—	1	—	—	—	—	—	—
Encephalitis Epid.	—	2	—	—	—	—	1	1	—
German Measles	8	4	3	2	18	6	8	4	5
Influenza	6	7	3	6	126	82	140	176	182
Malaria	—	—	—	—	—	—	—	1	—
Measles	122	121	179	128	262	192	286	242	257
Mumps	117	77	78	75	51	104	60	74	61
Paratyphoid Fever	—	1	—	2	—	—	—	—	—
Pneumonia (Broncho)*	59	40	43	22	53	23	36	41	91
Pneumonia (Lobar)	59	49	41	38	61	37	54	71	80
Poliomyelitis	—	1	—	2	—	—	—	—	—
Scarlet Fever	70	87	102	87	102	68	74	44	53
Septic Sore Throat	7	2	4	3	2	2	1	4	2
Smallpox	8	4	6	8	—	—	—	—	—
Tetanus	1	—	—	—	—	—	—	—	—
Trichinosis	—	—	—	1	—	—	—	1	—
Tuberculosis (Pul.)	31	34	18	34	28	29	22	32	28
Tuberculosis (O. F.)	4	6	4	2	1	1	2	3	—
Typhoid Fever	—	1	1	—	2	2	1	—	—
Undulant Fever†	—	2	—	—	—	—	1	—	—
Whooping Cough	122	106	112	123	72	58	52	77	50
Gonorrhea	30	25	40	25	27	27	16	80	11
Syphilis	38	39	66	58	33	55	23	54	46

*Made reportable January 1, 1925.
†Made reportable August 14, 1928.

Remarks: No cases of Asiatic cholera, glanders, plague and yellow fever during the past seven years.

DR. LORD ADDRESSES THE MID-SOUTH POST-GRADUATE MEDICAL ASSEMBLY

Dr. Frederick T. Lord, Clinical Professor of Medicine, Harvard Medical School, spoke on certain aspects of diseases of the bronchi, lungs and pleura on February 10 and 11 at the forty-eighth annual session of the Mid-South Post-Graduate Medical Assembly at Memphis, Tenn.

AN UNWARRANTED CLAIM

Requests have been made to physicians by a representative of a photographic company for orders with the alleged endorsement of the American College of Surgeons.

This claim is unwarranted as shown by the subjoined letter by Dr. Martin to one of the men who has been approached.

American College of Surgeons
40 East Erie Street
Chicago

February 6, 1932.

My dear Doctor:

I am very glad that you wrote me regarding the annoyance to which you have been subjected by the representative of the Keystone Views Company, of New York. That concern is entirely unknown to me and to the best of my knowledge we have never had any communication with it whatever. They are certainly not in any way authorized to take photographs for us nor to solicit Fellows of the College for that purpose. We have immediately

written them giving them due warning that all such methods must cease, since they are not only undesirable but unlawful. It is needless to add that whoever used the names of Dr. Kanavel and Dr. Miller as their endorsement in this connection was doing so without the slightest authorization.

Your photograph was taken, as you state, by Underwood and Underwood, and we have a copy in our files.

Thanking you for giving me this information and trusting that you will not be further annoyed, I am

Very truly yours,
FRANKLIN H. MARTIN,
Director-General.

THE DIPLOMATES OF THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The following physicians have successfully passed the examinations held by the American Board of Obstetrics and Gynecology and have received the diploma of the Board which certifies that these men have been duly accredited on the basis of specialization and proficiency:

Arkansas

Hinkle, S. B., Little Rock

California

Ainley, F. C., Los Angeles
Emge, L. A., San Francisco
Fist, H. S., Los Angeles
Lazard, E. M., Los Angeles
Lynch, F. W., San Francisco
McNeile, L. G., Los Angeles
Maxwell, Alice F., San Francisco
Moore, W. G., San Francisco
Newman, H. P., San Diego
Pierce, S. N., Los Angeles
Slemons, J. M., Los Angeles
Spalding, A. B., San Francisco
Stephenson, H. A., San Francisco

Colorado

Ingraham, C. B., Denver
Weiner, Morris, Denver

Connecticut

Cogan, G. E., Hartford
Creadick, A. N., New Haven
Hershman, A. A., New Haven
Howard, J. H., Bridgeport
Lewis, R. M., New Haven
Miller, J. R., Hartford
Morse, A. H., New Haven
Storrs, R. W., Hartford
Thompson, H. G., Hartford
Thoms, Herbert, New Haven

District of Columbia

Davis, Daniel, Washington
Garnett, A. Y. P., Washington
Jacobs, J. B., Washington
Kane, H. F., Washington
Willson, Prentiss, Washington

Georgia

McCord, J. R., Atlanta

Illinois

Adair, F. L., Chicago
Bacon, C. S., Chicago
Baer, J. L., Chicago
Bloomfield, J. H., Chicago
Browne, W. H., Chicago
Buxbaum, Henry, Chicago
Cary, Eugene, Chicago
Cornell, E. L., Chicago
Culbertson, Carey, Chicago
Curtis, A. H., Chicago
Danforth, W. C., Evanston
DeLee, J. B., Chicago
Dorland, W. A. N., Chicago
Edwards, E. A., Chicago
Falls, F. H., Chicago
Fischmann, E. W., Chicago
Fox, P. C., Oak Park
Frankenthal, L. E., Chicago
Frankenthal, L. E., Jr., Chicago
Galloway, C. E., Evanston
Goldstine, M. T., Chicago
Greenhill, J. P., Chicago
Grier, R. M., Evanston
Heaney, N. S., Chicago
Hesseltine, H. C., Chicago
Horner, D. A., Chicago
Jones, H. O., Chicago
Kanter, A. E., Chicago
Lackner, J. E., Chicago
Lash, A. F., Chicago
Reed, C. B., Chicago
Rudolph, Louis, Chicago
Schmitz, Henry, Chicago
Schochet, S. S., Chicago
Scott, R. A., Evanston
Simon, L. S., Chicago
Smith, P. H., Evanston
Stein, I. F., Chicago

Indiana

Bickel, D. A., South Bend
Gustafson, G. W., Indianapolis
Mendenhall, A. M., Indianapolis
Smith, D. L., Indianapolis

Iowa

Plass, E. D., Iowa City
Von Graff, Erwin, Iowa City

Kansas

Cowles, G. E., Wichita

Kentucky

McConnell, W. T., Louisville
Speidel, Edward, Louisville

Louisiana

King, E. L., New Orleans

Kostmayer, H. W., New Orleans
Miller, C. J., New Orleans
Miller, H. E., New Orleans

Maryland

Bergland, J. Mc F., Baltimore
Novak, Emil, Baltimore
Rowland, J. M. H., Baltimore
*Williams, J. W., Baltimore

Maine

Leighton, A. P., Jr., Portland

Massachusetts

Almy, Thomas, Fall River
Bristol, D. J., Jr., Boston
De Normandie, R. L., Boston
Good, F. L., Boston
Heffernan, R. J., Boston
Huntington, J. L., Boston
Irving, F. C., Boston
Jackson, D. L., Boston
Janney, J. C., Boston
Kellogg, F. S., Boston
Kickham, E. L., Boston
Lynch, F. J., Boston
Meaker, S. R., Boston
Paine, A. K., Boston
Pemberton, F. A., Boston
Phaneuf, L. E., Boston
Rushmore, Stephen, Boston
Shay, E. F., Fall River
Titus, R. S., Boston

Michigan

Bell, J. N., Detroit
Cummings, H. H., Ann Arbor
Kamperman, George, Detroit
Miller, N. F., Ann Arbor
Peterson, Reuben, Ann Arbor
Pierce, J. M., Ann Arbor
Seeley, W. F., Detroit
Yates, H. W., Detroit

Minnesota

Barry, L. W., St. Paul
Condit, W. H., Minneapolis
Ehrenberg, C. J., Minneapolis
LaVake, R. T., Minneapolis
Litzenberg, J. C., Minneapolis
Maland, C. O., Minneapolis
Manley, J. R., Duluth
Mussey, R. D., Rochester
Rothrock, J. L., St. Paul
Swanson, R. E., Minneapolis

Missouri

Calkins, L. A., Kansas City
Crossen, H. S., St. Louis
Crossen, R. J., St. Louis
Dorsett, E. L., St. Louis
Ehrenfest, Hugho, St. Louis
Gellhorn, George, St. Louis
Guffey, D. C., Kansas City
Hamilton, B. G., Kansas City
Hanna, M. A., Kansas City
Kerwin, William, St. Louis
Krebs, O. S., St. Louis
McNalley, F. P., St. Louis
Newell, Q. U., St. Louis
Paddock, Richard, St. Louis
Roblee, M. A., St. Louis
Royston, G. D., St. Louis
Schwarz, Henry, St. Louis
Schwarz, O. H., St. Louis
Swahlen, P. H., St. Louis
Taussig, F. J., St. Louis
Vogt, W. H., St. Louis

Nebraska

Findley, Palmer, Omaha
Sage, E. C., Omaha

New Jersey

Conoway, W. P., Atlantic City
Cosgrove, S. A., Jersey City
Darnall, W. E., Atlantic City
Hall, P. O., Jersey City
Ill, E. J., Newark
Mount, W. B., Montclair
Walker, R. B., New Brunswick

New York

Acken, H. S., Jr., Brooklyn
Adler, N. H., Brooklyn
Aranow, Harry, New York
Ayres, D. R., New York
Beck, A. C., Brooklyn
Bishop, Eliot, Brooklyn
Brandt, M. L., New York
Brettauer, Joseph, New York
Broder, N. E., New York
Brodhead, G. L., New York
Caldwell, W. E., New York
Cherry, T. H., New York
Clifford J. S., Rochester
Cohen, Moses, Long Island City
Corscaden, J. A., New York
Cowles, H. C., New York
Dannreuther, W. T., New York
Davis, G. H., Brooklyn
Dennen, E. H., New York
Dickinson, R. L., New York
Doyle, F. B., Brooklyn
Farrar, Lilian K. P., New York
Flint, Austin, New York
Frank R. T., New York
Freed, F. C., New York
Fulkerson, L. L., New York
Furniss, H. D., New York
Gamble, T. O., Albany
Geist, S. H., New York
Gibson, Gordon, Brooklyn
Goff, B. H., New York
Goldberger, M. A., New York
Goldsborough, F. C., Buffalo
Gordon, C. A., Brooklyn
Grad, Hermann, New York

*Deceased.

Hagstrom, H. T., Brooklyn
Hale, William, Jr., Utica
Halsted, Harbeck, New York
*Harper, P. T., Albany
Harrar, J. A., New York
Healy, W. P., New York
Hellman, A. M., New York
Hildreth, Warren, New York
Hoenig, Edward, New York
Holden, F. C., New York
Holladay, E. W., New York
Hornstein, Mark, New York
Humpstone, O. P., Brooklyn
Hyams, M. N., New York
Jacoby, Adolph, New York
Jarcho, Julius, New York
Jellinghaus, C. F., New York
Jewett, W. A., Brooklyn
Judd, A. M., New York
Kahn, I. W., New York
King, J. E., Buffalo
Knipe, W. H. W., New York
Kosmak, G. W., New York
Lilienfeld, M. C. C., New York
Lobsenz, Moses, New York
Loizeaux, L. S., New York
Lubin, Samuel, Brooklyn
Lyon, E. C., Jr., New York
McMahon, J. J., New York
McPherson, Ross, New York
Matthews, H. B., Brooklyn
Mayes, H. W., Brooklyn
Mencken, H. P., Astoria, L. I.
Miller, J. A., New York
Moench, G. L., New York
Murray, P. M., New York
Philip, Albert, New York
*Polak, J. O., Brooklyn
Potter, I. W., Buffalo
Potter, M. G., Buffalo
Quigley, J. K., Rochester
Rawls, R. M., New York
Rice, F. W., New York
Robinson, M. R., New York
Rongy, A. J., New York
Rosenfeld, S. S., New York
Rubin, I. C., New York
Ryder, G. H., New York
Safford, H. B., New York
Schoeneck, Henry, Syracuse
Schwartz, L. S., Brooklyn
Sears, N. P., Syracuse
Siegel, L. A., Buffalo
Smith, W. S., Brooklyn
Stander, H. J., New York
Stein, Arthur, New York
Stone, William, New York
Sturmdorf, Arnold, New York
Taylor, H. C., New York
Truex, S. L., Middletown
Van Auken, W. B. D., Troy

*Deceased.

Van Etten, R. C., New York
Ward, G. G., New York
Ward, Wilbur, New York
Watson, B. P., New York
Welton, T. S., Brooklyn
Wilens, Ira, New York
Williamson, H. C., New York
Wilson, K. M., Rochester
Wing, L. A., New York
Wolfe, S. A., Brooklyn

North Carolina

Procter, I. M., Raleigh

North Dakota

Moore, J. H., Grand Forks

Ohio

Bill, A. H., Cleveland
Bonifield, C. L., Cincinnati
Douglass, M. D., Cleveland
Gardiner, J. P., Toledo
Goodman, S. J., Columbus
Hoerner, J. K., Dayton
Krigbaum, R. E., Columbus
Miller, Theodore, Cleveland
Reycraft, J. L., Cleveland
Smead, L. F., Toledo
Tate, M. A., Cincinnati
Weir, W. H., Cleveland

Oregon

Mathieu, Albert, Portland
Schauffler, G. C., Portland
McCusker, C. J., Portland
Watkins, R. E., Portland

Pennsylvania

Anspach, B. M., Philadelphia
Barnard, E. P., Philadelphia
Behney, C. A., Philadelphia
Bland, P. B., Philadelphia
Carroll, T. B., Pittsburgh
Chalfant, S. A., Pittsburgh
Ely, W. C., Philadelphia
Fisher, J. M., Philadelphia
Foulkrod, Collin, Philadelphia
Gillis, R. A. D., Pittsburgh
Hammond, F. C., Philadelphia
James, D. B., Philadelphia
Keene, F. J., Philadelphia
Kimbrough, R. A., Jr., Philadelphia
Kocyan, J. J., Wilkes-Barre
Longaker, Daniel, Philadelphia
McCullough, F. J., Philadelphia
MacFarlane, Catharine, Philadelphia
Mazer, Charles, Philadelphia
Nicholson, W. R., Philadelphia
Norris, C. C., Philadelphia
Parke, W. E., Philadelphia
Piper, E. B., Philadelphia
Raymond, W. C., Johnstown
Reeves, T. K., Pittsburgh
Schumann, E. A., Philadelphia
Stevenson, J. W., Pittsburgh

Sturgis, Margaret C., Philadelphia
Taylor, J. S., Altoona
Titus, Paul, Pittsburgh
Tracy, S. E., Philadelphia
Vaux, N. W., Philadelphia
Williams, P. F., Philadelphia

Rhode Island

Appleton, Paul, Providence

South Carolina

Wilson, L. A., Charleston

Tennessee

Black, W. T., Memphis
Burch, L. E., Nashville
Pride, W. T., Memphis
Reinberger, J. R., Memphis
Toombs, P. W., Memphis

Texas

Bourland, J. W., Dallas
Cooke, W. R., Galveston
Hannah, C. R., Dallas

Virginia

Andrews, C. J., Norfolk
Baughman, Greer, Richmond
Rucker, M. P., Richmond

West Virginia

Bloss, J. R., Huntington

Wisconsin

Campbell, R. E., Madison
Davis, C. H., Milwaukee
Harris, J. W., Madison

Canada

Cleland, F. A., Toronto
Hendry, W. B., Toronto
Little, H. M., Montreal
Scott, W. A., Toronto
Van Wyck, H. B., Toronto

DOCTORS DISCIPLINED BY THE CHICAGO MEDICAL SOCIETY

The report that six physicians were expelled from the Chicago Medical Society January 12, 1932, for advertising is current.

The charge against them is in substance the use of newspapers in announcing low rates for a so-called Health Centre. One of this group is a member of the Chicago Board of Health.

THE MAGAZINES LOOK AT MEDICINE

Harper's Monthly Magazine for February.

"A Doctor's Wife Speaks Up." Anonymous.

An excellent article dealing with the practice of medicine, doctors' fees, patients, and hospitals. Written by a woman who knows what she is talking about.

The Ladies' Home Journal for March.

"Saver of Mothers" by Paul de Kruif.

The story of the Austrian physician Semmelweis, and his attempts to lessen the high mortality of mothers in childbirth, before the days of Pasteur. Hospitals then, and even now, are called "armed camps of streptococci" although the Chicago Lying-In Hospital is cited as an example of safety.

The New Republic for February 3.

"What's Stopping Birth Control?" by James Rorty.

Birth control is discussed in relation to unemployment. The author puts the problem up to "the medical profession and the privately financed social workers". It is to be supposed that he does not live in Massachusetts.

The Pictorial Review for March.

"The Question of Birth Control" by The Very Rev. William Ralph Inge.

A thoughtful and scholarly résumé of the historical background of birth control with special emphasis on the greatly differing birth rates of various countries.

MORTALITY RATES

Telegraphic returns from 83 cities with a total population of thirty-six million for the week ending January 30, indicate a mortality rate of 11.5 as against a rate of 15.1 for the corresponding week of last year. The highest rate (25.4) appears for Utica, N. Y., and the lowest (7.4) for Somerville, Mass. The highest infant mortality rate (11.5) appears for Birmingham, Ala., and New Bedford, Mass., and the lowest for Duluth, Minn., Erie, Pa., Long Beach, Calif., Miami, Fla., Minneapolis, Minn., Tacoma, Wash., and Tampa, Fla., which reported no infant mortality.

The annual rate for 83 cities is 12.0 for the four weeks of 1932, as against a rate of 14.4 for the corresponding period of the previous year.

FROZEN APPLES RETAIN VITAMIN C

Dr. S. S. Zilva and Miss M. F. Bracewell at the Lister Institute, London, and Dr. F. Kidd and Dr. Cyril West are reported to have found that Vitamin C is not destroyed when apples are frozen. In addition it is claimed that the skin and adjacent parts of the apple contain larger amounts of this vitamin.

VITAMIN B MAY INFLUENCE INTELLIGENCE

Professor E. V. McCollum of Johns Hopkins University in a recent address before the New York Academy of Medicine reports the results of experiments on rats by Drs. Siegfried Maurer and Loh Seng Tsai that vitamin B may have an important influence in promoting mental capacity.

Dr. McCollum, however, admits the possibility that the interpretation of the rats' response to the ingestion of vitamin B may not apply to the human spe-

cies although it is known that human and bovine milk is deficient in this vitamin.

The experimental application of vitamin B to infants with the proper controls presents some obvious objections, but even so, without controls general results may be useful.

HARVARD MEDICAL SCHOOL

Additional appointments (approved by the Corporation February 8, 1932):

For one year from September 1, 1931:

Edward Stanley Emery, Jr., M.D., Instructor in Medicine.

From November 1, 1931 to September 1, 1932:

John Harold Talbott, M.D., Research Fellow in Medicine.

From December 1, 1931 to September 1, 1932:

Myles Pierce Baker, M.D., Assistant in Medicine.

Ralph Weir Daffinee, M.D., Assistant in Pediatrics.

From January 1, 1932 to September 1, 1932:

Benjamin Max Banks, M.D., Research Fellow in Medicine.

Robert Montraville Green, M.D., Instructor in Obstetrics and in Gynecology.

Joseph Powitzer Cohen, M.D., Assistant in Obstetrics and in Gynecology.

Harold Valmore Hyde, M.D., Assistant in Obstetrics, in Anatomy, and in Gynecology.

Reginald Dimock Margeson, M.D., Assistant in Obstetrics, in Anatomy, and in Gynecology.

John Thomas Williams, M.D., Assistant in Obstetrics and Instructor in Gynecology.

THE APPOINTMENT OF DR. MARY POLAND SNOOK

Governor Ely has nominated Dr. Mary Poland Snook to the position of Associate Medical Examiner of the first Hampshire District. She succeeds the late Dr. W. P. Stutson of Cummington.

Dr. Snook resides in Chesterfield. She was born in Lebanon, New Hampshire, graduated from the University of New Hampshire and took her medical degree from Boston University School of Medicine.

She formerly practiced in Watertown, Massachusetts. She is a member of the Massachusetts Medical Society.

RECENT DEATHS

LOVEJOY — Dr. Charles Averill Lovejoy died February 17, 1932, in Lynn. Dr. Lovejoy was eighty-five years of age, a native of Nashua, New Hampshire, born in 1847. His premedical education was in the class of '68 of Harvard and his medical degree was conferred by the Harvard Medical School in 1872. He engaged in postgraduate study in England and Ireland. He joined the Massachusetts Medical Society in 1872. He was a member of the Oxford Club of Lynn and the Lynn Lodge of Odd Fellows. Three children survive him.

HOBBIE—Dr. John Remington Hobbie, a member of the Massachusetts Medical Society, died October 3, 1931. Dr. Hobbie was 79 years old. He graduated from the College of Physicians and Surgeons, Columbia University in 1877.

OBITUARY

HAROLD A. JOHNSON, M.D.

For the second time within a year we are gathered to pay a last tribute to a member of this Staff.

Hushed by the eternal silence, the echo of the voices so familiar to us in these meetings seems to linger within these walls. One particularly, so impressive, so earnest in discussion, so convincing in its clear, logical presentation of facts,—the voice of Doctor Harold A. Johnson.

In making a survey of a life, a few characteristics stand out as landmarks on a road widely traveled and traversed by sudden turnouts or dangerous precipices and when the voyager rests his weary head at night, on the whole, it's the enchanting beauty of its borders that makes a most lasting impression on him. It is this memory that he cherishes above all at the end of his journey.

Loyalty to this institution, loyalty to his confreres, absolute devotion to his work, when illness did not interfere with his professional duties, an exceptional grasp of the hard problems of his difficult specialty, an extraordinary faculty of clear statements, these were the outstanding characteristics of our friend and colleague, Dr. Johnson.

We, of his generation, shall miss his keen observations, his flashes of wisdom, his willingness to concede a mistake; and some of the younger men will miss his sound teaching, and the example of his skillful surgical technique.

Presented to the Staff of the Lynn Hospital by Dr. J. Armand Bedard. Dr. Bedard has since died.

NOTICES

UNITED STATES CIVIL SERVICE EXAMINATIONS

The United States Civil Service Commission announces the following-named open competitive examinations:

Senior Medical Officer	Cancer
Medical Officer	Diagnosis and
Associate Medical Officer	Treatment

Applications for the positions of Senior Medical Officer, Medical Officer, and Associate Medical Officer must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than March 22, 1932.

Full information may be obtained from the Secretary of the United States Civil Service Board of Examiners at the post office or customhouse in any

city, or from the United States Civil Service Commission, Washington, D. C.

MEDICAL CLINIC AT THE PETER BENT BRIGHAM HOSPITAL

At 3:30 P. M., on Thursday, March 3, in the Amphitheatre of the Peter Bent Brigham Hospital, a medical clinic will be given by Dr. Henry A. Christian, to which physicians are cordially invited. The clinics will be held regularly on Thursday afternoons.

RADIO HEALTH MESSAGES

MARCH, 1932

Sponsored by the Public Education Committee of the Massachusetts Medical Society and the Massachusetts Department of Public Health.

Courtesy WBZA. Tuesdays at 5:00 P. M.

March

1 The Psychology of the Crippled Child
8 Personal Rights vs. Public Safety
15 Electrical Hazards in the Home
22 Can High Blood Pressure Be Avoided?
29 Rose Cold and Hay Fever

STATE HOUSE BROADCAST

Sponsored by the Massachusetts Department of Public Health.

Courtesy WEEI. Fridays at 12:30 P. M.

Health matters of public interest discussed by the Division Directors of the Department.

RADIO HEALTH FORUM

Queries from the public are answered under the sponsorship of the Department of Public Health.

Courtesy WEEI. Fridays at 4:50 P. M.

Questions on Health and Prevention of Disease may be sent to: Radio Health Forum, State Department of Public Health, State House, Boston.

REPORTS AND NOTICES MEETINGS

THE HARVARD MEDICAL SOCIETY

The regular meeting of the Harvard Medical Society was held in the amphitheatre of the Peter Bent Brigham Hospital on January twenty-six. Dr. John Homans presided.

The medical case was presented by Dr. Evans. A thirty-year-old typist entered the hospital four weeks ago complaining of headache and vomiting of three days' duration. She had had frequent headaches all her life and had always been easily fatigued. Five years ago she had polyarticular arthritis. For the past three years she has had palpitation on excitement and edema of the ankles at night. Eighteen months ago she fainted. Nine months ago she had sudden blackness before her eyes, headache and vomiting. Subarachnoid hemorrhage was diagnosed in the Massachusetts General Hospital. She was told she had a blood pressure of 230, and was discharged on a low protein, low salt diet. She was well until three days before admission when the headache, vomiting and blurring of vision suddenly returned.

On entry she was somewhat comatose. The fundus showed the signs of hypertension, hazy discs, and a hemorrhage. The neck was stiff. The left chest was prominent. The heart was much enlarged, the sounds loud and booming. There were no signs of myocardial failure. The vessel walls were somewhat thickened. The diagnosis was hypertension and arteriosclerosis with subarachnoid hemorrhage. The latter was confirmed by lumbar puncture. This procedure was repeated every thirty-six hours. Her condition has gradually improved.

Dr. Bishop presented the surgical case. A thirty-five-year-old man cut a pimple on his face six days before admission while shaving. His face soon swelled greatly, nearly closing the eyelids, and on the day before admission he had chills and profuse perspiration.

On entry he had a temperature of 105°. He had a carbuncle of the lower lip which was discharging internally and externally. There was dulness over both lungs, and moist râles throughout the chest. Multiple small areas of consolidation in the lungs were shown by x-ray. Staphylococcus aureus was recovered from the facial lesion.

Pain in the mandible appeared several days thereafter, satisfactory drainage of the carbuncle was obtained after x-ray treatment, and necrotic bone was removed, but evidence of sepsis continued. A few weeks later he developed pain in the right side of the abdomen and the urine contained pus. A definite mass appeared about ten days later and exploration revealed a perinephric abscess, which was drained. Cultures showed Staphylococcus aureus. Since operation his temperature fell to normal.

Dr. Cheever, discussing the case, said that "pyemic" manifestations are observed most frequently in the liver, spleen, kidneys, and bones and that perinephric abscesses usually originate from septic renal infarcts.

Dr. Louise Eisenhardt spoke on "The Differentiation of Pituitary Adenomas by Supravital Technique." She has prepared a large number of specimens by this method, and demonstrated the close correlation which exists between the histologic structure and the clinical condition of the patient.

Pituitary tumors are divided into three groups. The first of these includes the chromophobe adenomas. Seventy-three per cent. of the series of pituitary tumors in the Brigham records are of this kind. Clinically, the patients generally show signs of glandular insufficiency. Histologically, the tumor is composed of round cells of uniform size. They contain a round or oval nucleus with a well-marked nucleolus. The cytoplasm is delicately granular;

by appropriate staining these granules are shown to be mitochondria.

Chromophile tumors compose the second group—20% of the series. They are of two types. The acidophilic adenomas contain alpha granules in the cytoplasm, and are characterized clinically by acromegaly. Basophilic adenomas contain beta granules. Their clinical manifestations are discussed below by Dr. Harvey Cushing. Histologically, the acidophilic type is composed of cells which vary greatly in size. The coarse alpha granules are abundant. Cells containing four to seven nuclei are common.

Mixed tumors comprise 7% of the series. Most of the cells are chromophobe, but among them cells with alpha granules at the periphery are found. Multinucleated cells are also present.

Dr. Harvey Cushing discussed "The Basophile Adenomas of the Pituitary Body and Their Clinical Manifestations." He has collected from his own records and from the literature a series of cases which form a distinctive syndrome, not previously attributed to this particular tumor of the pituitary.

Tumors of the pituitary, in common with those of other endocrine organs, are usually secretory. The degree of secretion is often not proportional to the size. It is not certain whether the three types of cells which compose the anterior pituitary are fixed types or represent only one cell in various stages of activity. Some believe a mother cell may become acidophilic, then basophilic, then disintegrate, or reverse its type to secrete again. Cell cultures have not been done to determine the truth of this theory.

It has been found, however, that the hormone which promotes growth, elaborated by the acidophilic cells, and a hormone affecting sexual activity, produced by the basophilic cells, can be separated. The chromophobe cells apparently are not secretory. Since there may be over or underactivity of both the acidophilic and basophilic cells, the indefinite terms "hyper-" and "hypo-pituitarism" should be discarded.

Basophilic adenomas of the pituitary were first described by Erdheim twenty years ago. Dr. Cushing, in 1912, described a peculiar case which presented a well-defined polyglandular syndrome. Since that time he has had five other cases of the same type. No autopsies have been obtained on this group. A few similar cases have been described in the literature. It appears that this polyglandular syndrome may occur with no endocrine pathology other than a basophilic pituitary adenoma, or, at most, with a moderate secondary adrenal hyperplasia. Adrenal adenomas are frequently but not constantly found.

The case observed in 1912 was a woman of 23 who had suddenly gained much weight. She had hypertension, adiposity of the face, neck and trunk, puffiness of the eyes, and slight blurring of the discs. The sella appeared somewhat eroded. Decompression was done without effect. A year later she returned with headache, pain in the back, and the signs of chronic vascular nephritis. She has since improved and is in good health.

The clinical syndrome typically comprises the rapid development of obesity in a young person in whom the adiposity is strikingly confined to the neck, face and trunk, the limbs remaining, by contrast, slender. With this change are associated purplish abdominal striae, amenorrhea and hypertrichosis (in females), moderate polycythemia, hypertension and chronic vascular nephritis, followed by osteoporosis, spontaneous fractures, especially of the sternum, clavicle and ribs, and subcutaneous abscesses. Spontaneous ecchymoses, and evidence of secondary endocrine disorders other than osteoporosis, that is, diabetes, increased metabolic rate and pigmentation, frequently occur.

It is observed most frequently in females, perhaps because the changes are more striking. Dr. Cushing has discovered only four cases in males. Clinically, the same features are presented except that there is a loss of hair rather than a hypertrichosis; sexual dystrophy is an early symptom.

One man was observed in the Brigham Hospital. He had rapidly gained weight. His face was puffy, his hair had ceased to grow, his skin was painfully sensitive and he had a marked glycosuria, which was very difficult to control. He progressively failed despite attempts to alleviate the diabetes. Believing that this was a case of basophilic pituitary adenoma, he was given x-ray treatments. There was an immediate and striking improvement. He has gained progressively since.

Spontaneous recovery of some of these cases indicates that there are waves of hypersecretion of the adenomas.

THE CONGRESS ON MEDICAL EDUCATION

The Congress on Medical Education, Medical Licensure and Hospitals, held annually in Chicago under the auspices of the American Medical Association, is an event which continues to arouse considerable interest. It met this year on February 15 and 16 with a program shorter than usual and with perhaps slightly diminished attendance. It may be that economy was a factor in preventing some representatives of all the participating groups from attending, as it certainly was among State Boards. Requests for delegates in several states met with the reply from governors that there was no money available for such purposes. The program promised discussion of a number of important matters.

The organizations participating in the Congress were the Council on Medical Education of the American Medical Association, the Federation of State Medical Boards (of licensure) of the United States, the Council on Physical Therapy of the American Medical Association, and the American Conference on Hospital Service. On Monday, February 15, in a room adjacent to the meetings of the Congress, there was held by the Central Council

for Nursing Education, an institute for lay boards of hospitals and public health nursing organizations.

The papers that were read will appear from time to time in the Journal of the American Medical Association, but brief comment on some of the more significant tendencies may be pertinent now. The problem of better distribution of medical service, in which the economic factor is so important, received considerable attention, and what seemed to be wise or unwise developments were noted. This is one of the gravest problems now before the profession, and while appropriate leadership by physicians is to be expected, anything like an adequate solution can be reached only by coöperation with and by other groups in the community. The personal nature of curative and palliative medical service must not be overlooked in the experimental search for types or organization by which alone greater efficiency can be secured. Commercialism may creep in as another danger and has already made significant onslaughts especially in "corporate" and contract practice.

A closer rapprochement between general and psychiatric medicine is evident; and the magnitude of medical care of the veteran, progressively advancing the government in the practice of medicine, threatens dislocations that are not at all in the direction of wise development. In the interest of the public, specialism, real and alleged, needs additional control, but, while statutory enactment may be necessary, the sentiment is strong that every other method of removing the real evil that exists should be tried first. Some radicals think the attack should be made in the medical school, by eliminating the "pretenders" as early as possible, a desirable end but most difficult of attainment. Some advocates of annual reregistration of physicians speak of it almost as a panacea for the ills of the profession so far as licensure is concerned. In any case it is one of the foundations for adequate enforcement of the medical practice act, and is now in force in eighteen states. It deserves more widespread adoption. In justice to boards of registration it may be said that they do not make the laws under which they act.

In the discussion of nursing education, a suggestion was made that ought to have the consideration of physicians. The problems of the nursing profession, now very serious, are in part at least problems for the medical profession also; the nursing profession should not be expected to solve them alone, and in fact cannot do so. The suggestion, therefore, made by Dr. E. P. Lyons, Dean of the Medical School of the University of Minnesota, was that the name and function of the Council on Medical Education and Hospitals be changed to the Council on Medical and Nursing Education and Hospitals. It will be interesting to see what the reaction of the medical profession will be to this proposal.

THE STAFF MEETING OF THE MASSACHUSETTS GENERAL HOSPITAL

The monthly clinical meeting of the Staff of the Massachusetts General Hospital was held in the Moseley Memorial Amphitheatre on February 11. Dr. G. W. Holmes presided.

Two patients, each of whom on entrance complained of dysphagia, were presented. The first was shown by Dr. Fuller Albright. A young woman had suffered from dysphagia for nearly three years before entry into the hospital for study. Physical examination was negative except for the presence of a marked systolic thrill over the base of the heart, felt only when the patient was lying down. By means of the barium meal a semicircular obstruction indenting the posterior wall of the esophagus at the level of the aortic arch was demonstrated. The filling defect was unaffected by medication. The arch of the aorta was observed to be entirely on the right side, while the aorta was seen as a loop in both oblique views.

A similar case from the German literature was reported in which the author concluded that the defect was due to the left subclavian artery passing between the vertebral column and the esophagus as it does in certain cases of right-sided aorta due to embryologic maldevelopment. Autopsy confirmed this conclusion. Dr. Albright's patient, having been told that the obstruction is not progressive, is reassured.

The surgical case was presented by Dr. Oliver Cope. A woman of 35 first began to have difficulty swallowing eight years ago. Three years ago gastrostomy followed by retrograde dilation of the esophagus was done at another hospital. Nine months ago she came to the Eye and Ear Infirmary. Here a mercury bougie was passed with relief for a time. An x-ray four months ago showed a dilation of the esophagus just above the diaphragm. It was believed that she had an ulcer at the lower end of the esophagus. Because of further loss of weight she was transferred to Dr. Churchill's service. A second gastrostomy was done three months ago to improve her condition.

Two weeks ago she was explored by Dr. Churchill. The operative field was prepared, after a preliminary crushing of the left phrenic nerve, by dividing the left ninth and tenth ribs in the mammary line, and by cutting the suspensory ligament of the left lobe of the liver. The lower three inches of the thoracic esophagus which was definitely dilated was freed by blunt dissection. No ulcer or fibrosis to suggest an ulcer was found. He then enlarged the cardiac orifice by what he termed an "inverted Finney pyloroplasty". Convalescence from this unique operation was uneventful. Her dysphagia is entirely relieved.

Dr. William C. Martin discussed "Lymphoma of the Stomach." He was able to collect 68 cases of gastro-intestinal lymphoma from the literature since it was first suggested in 1911. During this period

there have been 23 cases in the Massachusetts General Hospital. Preoperative diagnoses have been consistently wrong.

Forty-four per cent. of the group presented combined lesions of the stomach and intestine, twenty-two per cent. were in the stomach alone, twenty-seven per cent. in the small bowel alone. By x-ray, the lesion resembles carcinoma more often than ulcer or polyp. Occasionally the mucous membrane of the stomach outlined with barium resembles convolutions of the cortex. In differentiating lymphoma of the stomach and cancer, the presence of a filling defect in both stomach and duodenum is evidence in favor of lymphoma of the stomach and duodenum, since ulcer of the duodenum is extremely rare with gastric cancer.

Only eight out of twenty-one cases operated on in this hospital survived operation. There are two five-year radical cures reported in the literature.

"The So-Called Prepyloric Ulcer" was discussed by Dr. Aubrey Hampton. He showed that ulcers in this area are almost always carcinomatous, and only exceedingly rarely benign.

The prepyloric area is defined as the inch of stomach just above the pylorus. A survey of the records of the hospital showed that carcinoma was twelve times as frequent in this area as peptic ulcer. The benign ulcer is most frequently found in the middle half of the lesser curvature, at the pylorus, and in the duodenal cap. Carcinoma is most common at the pylorus, in the prepyloric area, and at the cardia; relatively it is uncommon in the medial half of the stomach.

In 128 cases of ulcer of the stomach operated on in the Massachusetts General Hospital in the past ten years, seventy-four per cent. were in the medial portion of the stomach, while only two were definitely prepyloric. On the other hand, Dr. Hampton was able to list nine cases in which the diagnosis of prepyloric benign ulcer was made, while in every instance the patient returned later with carcinoma at the site of the ulcer.

Dr. Langdon Parsons spoke on "Surgical Results in Carcinoma of the Stomach." He deplored the attitude of hopelessness assumed even by many surgeons about gastric cancer. While in 1915 there were only three five-year cures in the literature, advances in x-ray diagnosis and surgical technique have improved the prognosis.

He analyzed 232 cases which were admitted to the hospital with a diagnosis of carcinoma of the stomach in the interval 1922 to 1926. One hundred and thirty-nine of this group were operated upon. The average life expectancy of the unoperated cases was six months. The average group mortality of the operated cases was thirty per cent.; the life expectancy of the cases surviving operation was 18 months. Of this group, resected cases lived an average of 39 months; those with posterior or anterior gastroenterostomies averaged eight months; while those patients who were merely explored lived only three months.

Of the 37 cases which were resected, there were nine five-year cures, while six of the group are still living. Evidently the hope of cure lies in resection. Dr. Parsons believes that it should be done more frequently. For even if metastases are present the patient's life expectancy is increased, and life made more comfortable by this operation.

Only thirty-two per cent. of the cases resected had symptoms for six months or less, while forty-seven per cent. of the inoperable cases had symptoms for this time. The common symptoms in the resected cases were ulcer symptoms (41%), change in bowel habits (38%), loss of appetite (29%), and vomiting (29%).

Operative deaths were due most commonly to pneumonia or peritonitis, rarely to shock and cardiac complications.

The papers were discussed by Drs. Lincoln Davis, T. D. Jones, Tracy Mallory, and C. M. Jones. Dr. Chester Jones briefly outlined the manner in which lesions of the stomach are treated in the gastro-intestinal clinic of the out-patient department. Those in the prepyloric area are considered surgical. Those on the lesser curvature are to be called ulcer only if they can be carefully followed. It is necessary to watch them a reasonable time; the behavior of the ulcer in a short period is often not indicative of its true nature. Malignant ulcers cannot definitely be distinguished by their size, for many large ones disappear after medical treatment.

THE LEGISLATIVE COMMITTEE OF THE PLYMOUTH DISTRICT MEDICAL SOCIETY FEBRUARY 4, 1932

The Legislative Committee of the Plymouth District Medical Society held its fourth annual meeting at the Commercial Club, Brockton, Mass., on February 4, 1932. The committee, for the past four years, has entertained the Legislators of the Plymouth District at a dinner, after which speakers of prominence in the Massachusetts Medical Society have addressed the legislators in order to give information in regard to the various bills that come before the legislature of that year. This was one of the best meetings ever held. Among those present were: Senator Roger Keith; Representatives, Jabez Thompson of Halifax, William H. McCarthy of Rockland, John Q. Knowles, John B. Holmes, John J. Whalen, Joseph H. Downey of Brockton, William A. Brown of Abington, and Ira C. Ward of Plymouth.

Dr. McNamara, President of the Plymouth District Medical Society, gave a cordial greeting to Dr. Halbert G. Stetson, President of the Massachusetts Medical Society, Dr. Thomas H. McCarthy, Vice-President, and Dr. Thomas O'Brien, Secretary to the President, legislators and members of the medical society, explaining that this is the annual get-together when the members of the legislature are invited to come and talk over matters relating to public health in which we are interested. "We

feel," said Dr. McNamara, "that with our experience we should be able to inform our legislators about these matters. The chairman of our committee, the man who wrote letters to you, the man who has telephoned you, has given his time and energy in arranging this meeting. He has always been interested in legislative matters. He is the man who is responsible for this meeting. I shall turn it over to Dr. McCarthy, Chairman of the Legislative Committee and Vice-President of the Massachusetts Medical Society."

Dr. McCarthy:

"Dr. Stetson, Dr. O'Brien, members of the legislature and members of the medical society. The Massachusetts Medical Society employs no lobbyists, no paid attorney. They depend on advocating or opposing medical and health legislation through a committee of five members who conduct their legislative business in a conscientious and ethical way. They deal with the legislature of Massachusetts as they deal with their fellow practitioners. The code of the ethics of the Massachusetts Medical Society is high and therefore their dealings with the legislators are conducted on an elevated plane. Of course, we advocate the passage of certain bills relating to health and medical matters and oppose others unfavorable to public health and medicine. When we oppose or advocate bills the legislators of Massachusetts may rest assured that our action is on a high plane. Heretofore our method has commonly been to interview or write to legislators setting forth the attitude of the profession. We understand that many legislators are opposed to the 'buttonholing' method and several years ago we conceived the idea of inviting the legislators of Plymouth County to a meeting of this kind, giving them a fairly good meal, and having men who are familiar with facts respecting these bills explain them so that when they come up for enactment or for a hearing before committees you may act more intelligently in relation to them and so now for several years we have invited to these meetings distinguished members of the medical profession familiar with all the details of legislation and this we have now done hoping to win your approval. At other meetings I have asked the legislators present if they approved of this method and they unanimously advised that these meetings should be continued, so tonight we have again the great pleasure of having the President of the Massachusetts Medical Society with us. He is a busy man whose duties are many and varied. But he told me in a letter one week ago that he thought it was his duty to come down here and inform you in regard to some of these bills. Tonight he has traveled all the way from Greenfield, to be present. He is a man of high standing in the Massachusetts Medical Society, a noted surgeon in the western part of the state, delegate to the American Medical Association and is now chairman of the legislative committee of the Society. I take great pleasure in introducing Dr. Halbert G. Stetson, the president of our society."

Dr. Stetson:

"Mr. Toastmaster, Ladies, Doctors of Medicine and Doctors of law. This is the first year that I have had the good fortune or the misfortune (and sometimes I think it is a misfortune) when I have to look over these various bills and separate the good from the bad. You gentlemen of the Legislature have my interest because I think you deserve a lot of sympathy. There are always many bills before the legislature, that have to do not only with conditions affecting the Medical Profession but also the general public. Some of these bills are excellent, some are good, a few are fair and some are absolutely bad. Dr. McCarthy has told you and you know already the custom you have here in this County of meeting with the physicians and having, perhaps, something done toward separating the wheat from the chaff. As the President of the Massachusetts Medical Society, one of the largest societies consisting of 4700 of the 6700 physicians in the State of Massachusetts, I would like to impress upon you this fact that, of all these various bills which have been considered, we are striving to arrive at a fair and just estimate, approving those bills that should be endorsed, according to our judgment and trying to point out some of the flaws that are in the bad ones. I would like to bring before you gentlemen one point which is often misunderstood, the difference that may exist between a registered physician and a member of the Massachusetts Medical Society. A registered physician is one who has passed the State Board of Registration in Medicine and has been given the authority to practice medicine in the State of Massachusetts. For a man to become a member of the Massachusetts Medical Society, however, he must have other qualifications. He must, in addition to being a registered physician in Massachusetts, pass another examination before he can be admitted to the Society, not only as to his educational qualifications but his standing among his fellows. Forty per cent. of the possible 100% of the final decision is based upon the ethical qualifications of that man. In other words the Massachusetts Medical Society, with its record of 150 years, has always represented the highest standard. We don't especially want to advocate a measure which is going to appear to you gentlemen as of particular benefit to us but rather for the best interest of all of the people. Many of the measures which the Medical Profession advocates take profit from the doctor rather than provide large financial returns for him. We want to have the medical profession stand for something that is a credit to the society and the whole state. When better resources in medicine are available, the Massachusetts Medical Society will endeavor to have them within the reach of every citizen. There are only a few matters to which I want to call your attention. The

first is the vaccination bill. The Senate has defeated the bill for compulsory vaccination for private school pupils repeatedly. Just a word about this bill. There are three bills so far relating to vaccination. One of them is the perennial which calls for the revocation or abolishment of the existing law compelling preschool vaccination. This appears as regularly as do the flowers in spring and is designed to make vaccination voluntary. In regard to compulsory vaccination of children in private schools, most of you, I think, realize how this can prevent smallpox. I recall, as a student in the city of Baltimore, an old lady told me that she could remember when there were four or five coffins on the sidewalk containing corpses taken from the houses in that particular district, and waiting for the undertaker's wagon to pick them up. It seems almost incredible and yet it is a fact. At present, we don't see anything like that. The practice which has eliminated this high mortality rate is vaccination. Vaccination is 130 years old. It has practically wiped smallpox off the earth except in Fitchburg recently and other places where they have not generally applied vaccination, but you will notice that vaccination has stopped that epidemic in Fitchburg. Some years ago when in Boston I visited the legislature and one of its members, a good fellow and friend, took me onto the floor. This bill for the removal or abolishment of vaccination was up for discussion. I think it is what you call the third reading. The discussion was cut down to five minutes. At the time I went in a doctor from Martha's Vineyard was talking about vaccination and why it should be retained as one of the laws of the state. The longer I listened the more I thought that I didn't blame the legislators for voting against it. He was talking far above the heads of the legislators. When he finally finished a sea captain from New Bedford who had evidently spoken before on this bill made a few short remarks. He said, 'I know nothing about the theory of the prevention of smallpox by vaccination. I do know, however, that I had 15 men aboard my ship. Eleven had been vaccinated and not one of them got the disease. However there were four men aboard that had not been vaccinated and everyone of them contracted the disease. I hope this law will stay on the books.' The next man was one from Worcester. He was also discussing smallpox. He said, 'I don't think vaccination is a pleasant experience. We know, however, that it prevents smallpox and vaccination is better than smallpox and I hope this law will be kept on the books and I shall pray to God that the doctors will find something more agreeable than vaccination which will prevent smallpox.' There is no question that vaccination is unpleasant but at the same time far better than smallpox. For that reason I sincerely believe we shall keep vaccination on the books. There is one bill on which, I think, the physicians should have your support. It is House 284 introduced by Representative Kelley of Worcester and provides for vaccination of children in private schools and that no child shall be admitted to private schools unless vaccinated. Private school students and parochial students are exempt from this compulsory vaccination at the present time. This bill is supported not only by the great majority of the medical profession, and boards of health, but also by private school organizations and the heads of all the parochial schools in this state. It has come up before the Senate and has been turned down without even a show of hands. I feel that it is unfair to these children to say that Johnny Jones who goes to public school is vaccinated and Billy Smith who goes to the private school doesn't have to be vaccinated. The school officials are afraid at times that Billy Smith will come in and introduce smallpox and if he does the managers of the private school might have to shut up that school and go out of business for the rest of the year. Dr. Woodward, father of this bill, has advocated it for many years. I should almost say he is a grandfather by now. Dr. Woodward has been President of the Massachusetts Medical Society, chairman of the Worcester Chamber of Commerce and a very prominent member of our profession. He is the type of man who is pushing this bill year after year with the hope that some time the legislators will see fit to pass it and the Governor to sign it. I went to visit an uncle of mine in Montana once. He was a wheat raiser and had retired. I said, 'Well, did you make your money out of wheat?' He said, 'Doctor, I made enough to take care of myself the rest of my years. I always said that when I got money enough for my wheat I would retire. I waited 30 years and finally there came a time when the wheat was there and the price was right and I retired.' I think Dr. Woodward has that same feeling. He said that he hoped this bill would pass on its merits and in fairness to all children, I sincerely hope that the Senate will pay attention to it on its merits in fairness to children. The next bill House 60 pertains to cancer clinics. Personally I think cancer clinics have done much good in Massachusetts and I think that is the feeling of most of the physicians and of the State Department of Health. Some objection is raised by the medical profession because of the way in which these cancer clinics are carried on. I suppose to some extent the medical profession has a natural objection to cancer clinics being universal and treating all people, rich and poor. The doctor sometimes thinks of his education and how much it cost, from $5000 up, according to the length of time he was engaged in it and the expense of conducting a practice which is from $2000 a year up. When he sees people who are much better off in the world's goods than he is going to a cancer clinic for advice and treatment, who should be going to a physician, then the physician has ground for objection. If some central agency should say that you must come to this agency and have your legal problems

solved, rich and poor alike, there would be some objection on the part of lawyers. They already have objected because banks draw up wills and act as executors of estates and they feel that is not right. The doctor feels it is an encroachment on his practice since he must get a living the same as the rest of the people. The medical society wishes to take care of people if they need it and it is willing to do all it possibly can to care for those people who are not able to provide medical service for themselves. We are not offering any objection to this bill, we simply call to your attention the fact that sometimes there is a feeling on the part of the medical profession that it is not quite fair. The next bill, House 929, provides for the creation of a medical research board by the state. I think you will not consider this bill because it is a very expensive proposition. The feeling of the legislative committee of this society is that such a measure may not effect the best results when carried out under state control. Private enterprises, various hospitals and special funds are likely to have very much better results than it is possible to obtain through any organization of this sort. It requires expert organizations which are capable and which are endowed and organized to prosecute work of this kind. It might not be successfully carried out by the state. Two other bills of interest are House 906 and 1084 with relation to nurses not residents of the state who may have the privilege of practicing in the State of Massachusetts. It is a fact that a large number of nurses are secured by hospitals from colleges elsewhere. They are good workers and a large number stay in the state and ultimately become residents either by marriage or naturalization. If we have given them training in this state it seems as though it would be good business for the state to register these girls so that we could have the benefit of their experience. The other side is that they take the places of girls who are residents of the state. I don't think that is true. There are a good many girls who are trained nurses who are residents of the state but if we were limited to residents of the state or residents of the United States in our hospitals I am afraid we should run short. It is very difficult at times to get applicants for training schools in our hospitals. A few years ago just after the war it was impossible for training schools to get their full quota of students. In good times, girls in the states are few as compared with girls in other provinces who are willing to take up nursing. Perhaps the most important bill is the bill for chiropractors. This has been presented to you through the regular channels and also as a petition with 40,000 signatures. The physicians feel that there is a state board of registration in medicine which takes care of all graduates of medical schools who wish to practice medicine in this state. It also examines osteopaths who take practically the same examination. For 14 years an osteopath was the secretary of the board and he was a very good man and excellent secretary. He also had high ideals in medicine. It is felt that the chiropractic bill would open a field to lower the standards of medicine. This state cannot afford to have its standards lowered. At the present time, the standard of Massachusetts is one of the lowest in its requirements for registration. The standard set by the chiropractor it seems to us is lower than that provided for physicians. It provides for the support of a board consisting of three members and if we can judge from this bill it is to provide for the examination that, so far as standards are concerned, is very low. The medical profession throughout the state sincerely hopes that the legislators will not see fit to allow this bill to pass but will do their best to keep the standards that we already have. We should have them higher. I am very grateful for the opportunity of saying a few words about these bills as they appear to us and I have tried to make them as plain as possible. I trust that I have succeeded in my effort."

Dr. McCarthy:

"Dr. Thomas O'Brien, the next speaker that I am pleased to introduce, is the Professor of Clinical Medicine at Tufts College; attending physician at Boston City Hospital and Executive Assistant to the President of the Massachusetts Medical Society. He is the one that we depend upon to study the bills, relating to medicine and public health, that come before the legislature. He is thoroughly familiar with them. When he finishes his address he will answer any question you may ask."

Dr. Thomas O'Brien:

"Mr. Chairman and friends. When Dr. McCarthy invited me to come I accepted so quickly, I think he was surprised. I was honored by your hospitality last year. Dr. Murdock was a classmate of mine. Dr. Richmond was one of my internes in the Boston City Hospital. Representative Knowles is a close friend and I had the pleasure of meeting the rest of you last year. We would feel more at home in addressing a class at the medical school or in an operating room. We know very little of the laws of debate. We cannot present our arguments properly; we are not parliamentarians. I am afraid that the legislators pity the weak manner in which we present our bills. Now, though we lack in argument or presentation, we want you to feel that we are in earnest. We have nothing to offer in exhibition of eloquence, but we feel that we have a right to ask consideration of health measures.

"We are proud of the record of our accomplishments. When I tell you that the expectancy of life in India is twenty-five years, and that at the time of George Washington in this country it was 35 years and today it is 58 years, the layman owes the medical profession something. This progress has been brought about by hard work and research and is based on scientific care and study but it is not made by manipulation of joints, placing the hands on the back or attempts to adjust the spine. Formerly a large percentage of children died of diphtheria. Today we

lose but three out of a hundred. With the treatment of toxin antitoxin derived from an immunized horse, the disease can be prevented. When I tell you that a large percentage of our insane are syphilitics, that we have a preparation which cures that disease in the early stages and diagnostic tests which are dependable, you must realize that progress has not come about by manipulation of the spine or other unreasonable methods. Further illustrations of progress referred to typhoid fever and malaria. If the health officer of your city is here tonight, I would like to have him tell you how many cases of typhoid or malaria are to be found in Brockton today. It will be a surprisingly small number. That is because of what medicine has done. Lister discovered in 1870 the secret of antisepsis which brought about a new surgery. More women had died of childbirth than men killed during war previous to Lister's discovery. Now if a life is lost we are disturbed and feel that an explanation is in order. We are menaced by a bill which comes before the legislators asking for recognition of a group which claim that there is no such thing as a germ. All conditions are due to changes in the spine, the nerves are pinched and when they manipulate the spine, the man gets well. It makes no difference whether it is malaria, typhoid, diabetes, or diphtheria, he gets well. At the hearing in 1924, a man came from Marlborough and testified that he had had diabetes and that he was being treated by a Boston physician who would not let him eat the things he wanted so he went to a chiropractor and had his back rubbed. He said, 'Gentlemen, I am cured.' And the lady who represented this city and sat at that public health meeting said, 'Isn't the progress that medicine has made wonderful?' I had the sad duty of going to Marlborough to get that man's death certificate one month from the time that he stood in the State House proclaiming that he was well. When these individuals come before you to testify about their conditions you must pity them. This man's life was sacrificed. Now it would seem that we are jealous of these individuals. When they come up to a certain standard, we are willing to accept them. In 1894, the legislature of Massachusetts passed a law requiring physicians to be registered. Somebody said that previous to that time it cost $2.00 to be a dog, but you could be a doctor for nothing. Any man could tack up a sign and practice medicine. In the early 1900's the osteopaths came asking for the privilege of practicing and in 1909 the bill was so amended that they were permitted to take the examination. At present the osteopath takes the same examination that everybody else does. By passing that examination he is permitted to practice in this state. We cannot conceive of one law to a man who drives a Ford and another for a man who drives a Rolls Royce. We cannot conceive of a man who practices pharmacy in a drug store taking the same examination as a man who graduates from a college of pharmacy. The same thing is carried out in law. A man who goes to the evening school of Boston University or Harvard must pass the same examination as the man who goes to day school in order to be admitted to the bar. Yet these individuals come before the public and say, 'We must have special privileges.' Chiropractic isn't practicing medicine; it is practicing Chiropractic. A chiropractor by the name of Zimmerman was arrested. His case was carried to the Supreme Court of Massachusetts. He was fined $300 and forced to leave the state. This man said he was practicing chiropractic only, not medicine, because he did not give medicine and did not do surgery. Their bill a few years ago requested the right to take care of a pregnant woman after parturition. Since 1922 chiropractic bills have been presented and rejected. The education of a chiropractor may be limited as shown by the fact that there is a doctor in Boston who without using his name or his title wrote to a chiropractic school for information about the course of study. He received the lectures by mail and after 18 hours of study became a doctor of chiropractic and was given a diploma. Can you compare such a person with representative surgeons and internists and believe for one moment that manipulation of the spine will bring about results comparable with the benefits received from well-educated physicians? Apparently people believe the claims of the chiropractor. One hundred thousand signatures have been obtained to a petition and 40,000 accepted by the Secretary of State as legal. Their statements were amplified by an explanation of the psychology of appeals for signatures on petitions. I am very happy to be with you this evening."

At the conclusion of Dr. O'Brien's address there was a question period. Senator Keith, the Representatives and physicians who were present asked numerous questions relating to the subjects discussed. It was without doubt the best meeting ever held by the Legislative Committee of the Plymouth District Medical Society. Dr. John J. McNamara closed the meeting by thanking everyone present for their interest. He said that without doubt the Plymouth District Society was the pioneer in this movement and he sincerely hoped that every district in the State would be inspired to adopt the practice of holding meetings for the discussion of legislation in order that medical bills might be explained and the profession protected from outside interference in lowering the standards of medical education that the Massachusetts Medical Society now upholds.

GREATER BOSTON MEDICAL SOCIETY

A joint meeting of the Greater Boston Medical Society and the Beth Israel Hospital will be held on Tuesday, March 1, 1932, at 8:15 P. M., at the Beth Israel Hospital.

PROGRAM

A Biological Concept of Disease. Dr. Eli Moschcowitz, Mt. Sinai Hospital, New York.

Discussion from the floor.

BERNARD I. GOLDBERG, M.D., *Secretary.*

NEW ENGLAND HEART ASSOCIATION

Cardiac Course

The fifth meeting of the Cardiac Course of the New England Heart Association for the season 1931-1932 will be held in the Boston Medical Library (John Ware Hall) on Wednesday, March 2, at 4:30 P. M.

Effect on the Heart of Diphtheria, Scarlet Fever and Tuberculosis

1. Pathology. Dr. Ralph L. Irwin.
2. Clinical Aspects of the Heart in Diphtheria and Scarlet Fever. Dr. Edwin H. Place.
3. Tuberculosis and the Heart. Dr. John B. Hawes, 2nd.
4. Discussion. Dr. Conrad Wesselhoeft.

All who are interested are invited to attend.

Paul W. Emerson, *Secretary.*

INTERNATIONAL CONGRESS ON BILIARY LITHIASIS

A large number of papers will be read at public meetings which will be attended by all sections of the International Congress on Biliary Lithiasis, to be held at Vichy from the nineteenth to the twenty-second of September 1932, under the patronage of the distinguished Minister of Public Health, and at which 38 countries will be represented.

Congress Committee: Professor Paul Carnot, President. Professors Maurice Loeper, President of the Medical Section—Pierre Duval, President of the Surgical Section—Maurice Villaret, President of the Therapy and Hydrology Section—Drs. J. Belot, President of the Electroradiology and Physiotherapy Section—J. Aimard, General Secretary, and R. Glenard, Assistant Secretary.

Applications for tickets and enquiries should be addressed to the General Secretary of the Congress—24 Boulevard des Capucines, Paris.

HARVARD MEDICAL SOCIETY

The next meeting of the Harvard Medical Society will be held in the Peter Bent Brigham Hospital Amphitheatre (Van Dyke Street entrance) Tuesday evening, March 8, at 8:15 o'clock.

Program

Presentation of cases.

Giant Tortoises and Pythons and their Contribution to Physiology, by Dr. Francis G. Benedict, Director, Carnegie Nutrition Laboratory.

Medical students and physicians are cordially invited to attend.

John Homans, *Secretary.*

AMERICAN SOCIETY FOR THE CONTROL OF CANCER

The annual meeting for the members of the American Society for the Control of Cancer will be held at the New York Academy of Medicine, 2 East 103rd Street, New York City, on Friday, March 4, 1932, at 8:00 P. M. We urge all members to attend and bring as many guests with them as they desire.

The program is as follows:

Presiding—J. M. Wainwright, M.D., President, American Society for the Control of Cancer.

1. "Recent Developments in the Work of the American Society for the Control of Cancer."—C. C. Little, Sc.D., Managing Director, American Society for the Control of Cancer.
2. "The Program and Work of the New York City Cancer Committee."—John C. A. Gerster, M.D., Chairman, New York City Cancer Committee.
3. "The Program and Work of the New York State Institute for the Study of Malignant Disease and the New York State Committee of the American Society for the Control of Cancer."—Burton T. Simpson, M.D., Director, New York State Institute for the Study of Malignant Disease and Chairman of the New York State Committee of the American Society for the Control of Cancer.
4. Business Meeting.

SOCIETY MEETINGS CONGRESSES AND CONFERENCES

February 26—New England Pediatric Society. See page 369, issue of February 18.

February 26—Belmont Medical Society. See notice on page 370, issue of February 18.

March 1—Greater Boston Medical Society. See page 426.

March 2—New England Heart Association. See notice elsewhere on this page.

March 3—Medical Clinic at the Peter Bent Brigham Hospital. See page 419.

March 4—American Society for the Control of Cancer. See notice elsewhere on this page.

March 8—Harvard Medical Society. See notice elsewhere on this page.

March 11 - May 6—The William Harvey Society. See page 745, issue of October 8.

March 26—Examination Conducted by the American Board of Obstetrics and Gynecology (written)—May 10 (general, oral and clinical). See page 252, issue of February 4.

March - April, Autumn — International Postgraduate Courses in Berlin. See page 1169, issue of December 10.

April 4-8—The American College of Physicians. See notice on page 1232, issue of June 4.

May 9-13—American Medical Association, New Orleans, La.

June 8, 9, 10—Massachusetts Medical Society, Hotel Statler, Boston.

June 21-24—Catholic Hospital Association. See page 369, issue of February 18.

September 19-22 — International Congress of Biliary Lithiasis. See notice elsewhere on this page.

October 24-27—American Public Health Association. See notice on page 1321, issue of December 31.

October 24-28—Inter-state Postgraduate Medical Association of North America. See page 39, issue of January 7.

DISTRICT MEDICAL SOCIETIES

Essex North District Medical Society

May 4—Annual meeting at Lawrence.

Essex South District Medical Society

March 2, Wednesday—Lynn Hospital. Clinic 5 P. M. Dinner 7 P. M. Speaker: Dr. Elmer W. Barron, Boston.

April 6, Wednesday—Essex Sanatorium, Middleton. Clinic 5 P. M. Dinner 7 P. M. Speaker, Dr. Arthur P. Wakefield, State Department of Health. Subject: 10-Year Tuberculosis Program in the Public Schools.

May 5, Thursday—Censors' Meeting, Salem Hospital, 3:30 P. M.

May 10, Tuesday—Annual Meeting. The Tavern, Gloucester. Speaker and subject to be announced later. Ladies invited.

Franklin District Medical Society

Meeting will be held on the second Tuesday of March and May at the Weldon, Greenfield, at 11 A. M.

CHARLES MOLINE, Secretary.

Middlesex East District Medical Society

At a meeting of the executive committee the following schedule for the Middlesex East District Medical Society was arranged:

March—At Reading.

May—At Woburn.

Meetings on the second Wednesday of each month unless otherwise announced.

Norfolk District Medical Society

March 29—Place to be announced. Boston Public Health Meeting. Speakers, Honorable James M. Curley, Dr. Francis X. Mahoney, Dr. Charles Wilinsky, Dr. W. H. Griffin.

May—Annual Meeting, date and place to be announced.

May 5—Censors' Meeting for examination of candidates. Roxbury Masonic Temple, 171 Warren Street, Roxbury, 4 P. M. Fee $10.00 payable at time of examination. All candidates will have applications in the hands of the secretary one week prior to this date. All candidates from Medical Schools not on approved list of Society must have application complete two weeks prior to date of examination.

F. S. CRUICKSHANK, Secretary.

Norfolk South District Medical Society

March 3—Speaker: Roderick Heffron, M.D. Subject: Pneumonia.

April 7—To be announced later.

May 5—Annual Meeting.

The time of all meetings is 12 o'clock noon, at the Norfolk County Hospital, South Braintree. Censors will meet on May 5 at 11:15 A. M. at the Norfolk County Hospital.

N. R. PILLSBURY, Secretary.

Suffolk District Medical Society

March 30—Clinical Program, New England Deaconess Hospital.

April 27—The Annual Meeting, Boston Medical Library. Election of Officers.

The Medical Profession is cordially invited to attend all of these meetings.

REGINALD FITZ, M.D., Vice President.
LELAND S. McKITTRICK, M.D., Secretary.
HILBERT F. DAY, M.D., Boston Medical Library.

Worcester District Medical Society

Wednesday evening, March 9 — Memorial Hospital, Worcester, Mass. 6:30—Dinner, complimentary by Memorial Hospital. 7:45—A pediatric meeting with subjects to be announced later.

Wednesday evening, April 13—Grafton State Hospital, North Grafton, Mass. 6:30—Dinner, complimentary by Grafton State Hospital. 7:45—Program to be announced later.

Wednesday afternoon and evening, May 11—Annual Meeting. Program to be announced later.

ERWIN C. MILLER, Secretary.

BOOK REVIEWS

Glasgow Royal Maternity and Women's Hospital Medical Report for the Year 1930. Prepared by H. R. MacLennan, M.B., Ch.B. Glasgow: Aird & Coghill, Ltd., 1931.

This somewhat belated Medical Report of the Glasgow Royal Maternity for 1930 presents the work of that Institution for that calendar year, during which time 4469 patients were admitted. Of these, 2809 were delivered, the remainder being Gynecological and non-maternity cases. There were 119 maternal deaths of which 22 were from sepsis, 22 from toxemia, 17 from antepartum and 14 from postpartum hemorrhage. Other statistics of interest are presented in tabular form. The report is a valuable summary of a year's work in a large, municipal maternity clinic.

A Text-Book of Clinical Neurology. By Israel S. Wechsler, M.D. Philadelphia and London: W. B. Saunders Co. 2nd edition, revised, 1931. 759 pages. Price $7.00.

The second edition of this well-known textbook contains only fifty more pages than the first edition. There has been considerable rearrangement of the material, however, and such subjects as encephalography, the pathology of brain tumors, and the latest researches on the epilepsies have been added. The first edition was reviewed in the *Boston Medical and Surgical Journal*, June 2, 1927, and the reviewer at that time pointed out that this is a *personal* textbook, based on Dr. Wechsler's experience at the Vanderbilt Clinic and the Mt. Sinai and Montefiore Hospitals in New York. The arrangement of the material is excellent and the few illustrations well chosen. The need for a second edition within four years is a good estimate of the value of this book to the medical profession. It is the best short American neurology today and is thoroughly up-to-date.

Practical Treatise on Diseases of the Digestive System. By L. Winfield Kohn. F. A. Davis Co., Philadelphia. Price $12.00.

This work suffers little from sins of omission. Like many others of its kind the volumes contain altogether too much material that is of very little value, and amidst the great mass of material the reader has great difficulty in separating the important from that which is practically worthless. Much that is included involves discarded physiologic concepts and the general picture frequently is confusing. Another fault, also of frequent occurrence in books of this type, is the treatment of symptoms and diseases on an equivalent basis. Repetition is therefore not uncommon and there are occasional contradictions. A thorough discussion is impossible in a short review but the relative importance placed on gastroscopy and gastrophotography, and the relatively poor description of sigmoidoscopy illustrates the unfortunate lack of discretion employed in placing emphasis upon proper subjects.

Therapeusis, at times discussed conservatively, is finally assembled in tremendous array and every conceivable means of therapy, pharmacologic and physical, is presented without any real attempt to enable the reader to choose between valuable measures and those of little or very questionable value. It seems as if the author feared to omit anything that had ever been mentioned or conceived. The discussion of extragastro-intestinal physiology and pathology, and the final section on surgery are of negligible value. Altogether the two volumes form an extremely disappointing addition to the literature.